VA AMBULATORY CARE TIMELINESS AND RELATED ISSUES

HEARING

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

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CONTENTS

MATERIAL SUBMITTED FOR THE RECORD

VA AMBULATORY CARE TIMELINESS AND RELATED ISSUES

WEDNESDAY, OCTOBER 27, 1993

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 8:30 a.m., in room 334, Cannon House Office Building, Hon. Lane Evans (chairman of the subcommittee) presiding.

Present: Representatives Evans, Waters, Gutierrez, Long, Ridge, and Quinn.

OPENING STATEMENT OF CHAIRMAN EVANS

Mr. EVANS. The hearing will come to order. Good morning and welcome.

Today, we are meeting to examine the timeliness of VA outpatient care delivery and related issues. Are veterans receiving timely outpatient care today from the VA, or are they forced too often to undergo long waits for care, even with scheduled appointments?

VA officials are fond of saying that if you have seen one VA medical center, then you have seen only one VA medical center. What this means, of course, is that each individual VA medical center is distinct and unique.

While no two VA medical centers are identical, too many, unfortunately, are alike in making veterans wait too long to receive basic outpatient care and related services like filling prescriptions.

At some VA facilities, veterans with long-standing appointments are forced to wait hours to receive their scheduled care while other veterans, after literally waiting all day are told, "Come back tomorrow." Long lines and long waits for care are agonizing, particularly for ill veterans and their families and those veterans who have traveled many miles or hours to get to the VA.

In calling for national health care reform, President Clinton has proposed that the VA compete to provide the health care needs of veterans. Like many others, I believe veterans can benefit from a competitive VA. To be truly competitive, however, the VA must solve the health care delivery problems veterans are experiencing today. Widespread and long delays in VA outpatient care and more "business as usual" will just not be good enough.

Today we will receive the results of a GAO review of VA outpatient care timeliness requested by the subcommittee. From our witnesses we will learn about the problems and opportunities

which exist for improving delivery of VA outpatient care on a timely basis. Officials representing the VA will hopefully give us their blueprint and timetable for actions to eliminate this chronic systemic problem.

Our first panel today is comprised of Dave Baine, Director of Federal Health Care Delivery Issues, Human Resources Division of the U.S. General Accounting Office. He is accompanied by Paul Reynolds, Human Resources Division Group Director, and Dot Barrett, a Senior Evaluator in GAO's Philadelphia office.

Without objection, Dave, your entire statement will be made part of the record, and you are invited to summarize your remarks and proceed whenever you are ready.

STATEMENT OF DAVID P. BAINE, DIRECTOR, FEDERAL HEALTH CARE DELIVERY ISSUES, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY PAUL REYNOLDS, GROUP DIRECTOR, HUMAN RESOURCES DIVISION AND DOROTHY M. BARRETT, SENIOR EVALUATOR, PHILADELPHIA OFFICE

Mr. BAINE. Thank you, Mr. Chairman, and good morning. We appreciate the opportunity to discuss the timeliness of care veterans receive in outpatient facilities operated by the VA.

Witnesses have testified before the House Veterans' Affairs Committee in 1991 and more recently last July before this subcommittee about long waits for care at VA ambulatory care clinics. In response to earlier concerns, you asked us to examine the ambulatory care system to determine how long veterans wait for care, identify factors causing service delays, and recommend ways to shorten veterans' waiting times.

To do this, we focused on VA's emergency screening clinics which are entry points for veterans seeking care, and specialty clinics such as those for cardiology and orthopedics which provide care for more complex medical conditions.

As we reported to you in mid-October, veterans too often encounter lengthy waits for care in VA clinics. Veterans served in more than 200 emergency screening clinics we surveyed frequently waited one to three hours or longer before physicians examined them for nonurgent conditions. In addition, veterans waited eight to nine weeks on average for appointments to the more than 700 specialty clinics we surveyed.

Mr. Chairman, inefficient operating practices are the major contributors to veterans' service delays. These practices result in many veterans with nonurgent conditions arriving unscheduled at emergency clinics and receiving care on a first come, first served basis. This, in turn, often results in uneven workloads for staff at the clinics and overcrowding during peak periods.

Also, VA operating policies allow many veterans to receive general medical care in specialty clinics after their medical conditions have been stabilized, thereby resulting in overcrowding of these clinics, as other veterans needing specialty care are referred to the same clinics.

Let me take a moment to describe in a little more detail some of the major causes of service delays in screening clinics and specialty clinics as well as some approaches we ran across as we trav-

eled around the country that facilities have been using to try to fix this problem.

During our visits to seven emergency screening clinics, we saw firsthand many overcrowded conditions where veterans were waiting for care. Too often we found veterans waiting needlessly for general medical assistance that could have been provided much more efficiently by telephone or through a scheduled visit.

For example, we identified many instances where veterans were required to travel to clinics, go through time-consuming processing requirements, and wait to see doctors merely to have their prescriptions refilled. These types of delays occur because VA's ambulatory system is not set up to handle most veterans' conditions efficiently.

VA officials estimated that nearly three-fourths of the veterans who came to screening clinics have nonurgent conditions, meaning that they were neither life- nor limb-threatening and were not time-sensitive. VA's ambulatory care system forces these veterans to walk into the VA's clinics regardless of their medical needs.

Our survey showed that only 18 percent of all visits to screening clinics were scheduled. Because nonurgent veterans are treated on a first-come, first-served basis, they tend to arrive early in the morning and overwhelm clinic staff. Officials believe that such uneven workloads contribute to long waits, dissatisfied veterans, and stressful working conditions for the VA staff.

VA facilities have independently taken a variety of steps to reduce veterans' waiting times. A few facilities have developed alternative delivery options such as telephone assistant networks that attempt to resolve veterans' problems by phone or through scheduled clinic visits.

One facility reduced the volume of veterans walking into their emergency clinic by 18 percent after adopting a telephone assistance network. About 60 percent of nonurgent veterans at this facility waited less than 30 minutes for physician evaluations compared to only 17 percent systemwide.

Another facility restructured its ambulatory care system using primary care providers as the cornerstone. Veterans are assigned to primary care providers who assure the continuity of care from the time a veteran first arrives for service until the veteran is discharged. This facility decreased the number of veterans in the emergency clinic and assigned nonurgent walk-ins to primary care providers at scheduled times.

During our visits to the medical centers, Mr. Chairman, we also reviewed several specialty clinic schedules and found that veterans often had to wait several months to see specialists. These long delays frequently recur at specialty clinics because too many veterans continue to receive follow-up care in these clinics after their conditions are stabilized. Filling clinic schedules with such patients contributes to long appointment waits for new patients.

As with the emergency clinics, the facilities around the country have independently taken a variety of steps to reduce appointment delays. Some have reviewed medical requirements of veterans being treated in specialty clinics and then transfer those veterans back to a general medicine clinic for routine care. Other facilities

have used primary care providers to coordinate the specialty referrals.

Mr. Chairman, in his recent proposal to reform the Nation's health care system, President Clinton proposed that VA compete with other providers to meet the health care needs of our Nation's veterans. VA's ability to service patients in a timely way will, in our view, be a key factor that veterans will consider when choosing their health care plan in a reformed health care system.

VA has not heretofore placed sufficient emphasis on the need for timely ambulatory service to veterans, as evidenced by the fact that it does not keep systemwide data on waiting times for care, neither has it established department-wide performance goals against which individual facilities' waiting times can be monitored and corrective actions taken.

We believe the VA needs to restructure its ambulatory care delivery system to provide timely patient-oriented service that meets veterans' varying health care needs. To do this, we recommended in our October 1993 report that VA focus on basic process changes such as establishment of telephone assistant networks and scheduling systems to expedite veterans' access to care for nonurgent conditions.

Moreover, VA needs to identify the best practices in use at its various centers and develop a strategy for replicating them throughout the system and establish department-wide performance goals to reinforce a renewed emphasis on reducing waiting times in VA clinics.

From a veteran's perspective, having a single primary care provider who is familiar with his or her condition, who will be accessible for nonurgent problems and coordinate his specialty care, seems to us to be desirable. Such an approach will counteract complaints about fragmented and episodic care that we heard in our travels around the country and reduce waiting times in both screening clinics and specialty clinics.

The Secretary of Veterans Affairs, in a letter dated October 5, 1993, stated that he generally agreed with the findings and conclusions in our report. He stated that VA is developing a strategic planning goal to implement a managed care approach that focuses on primary care. Through this effort, VA expects to enhance services to veterans as well as address our recommendations.

VA seems to be moving in the right direction. However, identifying the causes of service delays and reaching conceptual agreement on potential solutions may be the easier part of VA's challenge. Implementing the needed changes in a system as large as VA's will be a formidable task. This is because such implementation will entail shifting medical centers' ambulatory care emphasis from a specialty orientation to one focused on primary care and a corresponding reallocation of resources to make that shift happen.

In summary, Mr. Chairman, VA has a responsibility now and in the future to provide veterans of this country with timely health care. Clearly, it has some catching up to do. We think that our recommendations offer sound first steps toward meeting this responsibility. More importantly, overhauling the ambulatory care system and doing it quickly is essential if VA is to be a viable competitor under the President's health care reform proposal.

We will be more than glad to take your questions.

[The prepared statement of Mr. Baine appears at p. 53.]

Mr. EVANS. Thank you Dave. We appreciate your work on this issue.

Let me recognize the distinguished ranking member of the subcommittee, Congressman Tom Ridge of Pennsylvania.

OPENING STATEMENT OF HON. THOMAS J. RIDGE

Mr. RIDGE. Thank you, Mr. Chairman.

I would ask unanimous consent that my opening statement be included as part of the record and just commend you for holding this hearing and congratulate you on your foresight.

I think it was two years ago that you suggested that the GAO take a look at the ambulatory care services and practices within the VA health care delivery system, and once again it is a significant statement of your continuing commitment to improve the quality of care in the VA system for all veterans. So I am pleased to be with you this morning and pleased to take testimony.

Thank you.

[The prepared statement of Congressman Ridge appears at p. 49.]

Mr. EVANS. Thank you. Your entire statement, including those generous comments, will be made part of the record. I appreciate it.

You indicated that you didn't believe that veterans would select the VA if under national health care reform the VA competes for patients. They won't select VA if these long waits continue?

Mr. BAINE. Yes, sir, I did indicate that, and I believe that is true. It is our sense that in order to be competitive, VA really has to reinvent—to use a term that is in vogue now—reinvent its ambulatory care system.

The reason for that is that the system has been traditionally based on specialty—it is essentially a specialty system, and, quite honestly, the focus of the VA health care system heretofore has been on inpatient care. So not a lot of attention has been given to the ambulatory care portion.

Under national health reform, as I understand it, primary care, or managed care, is going to be a very important component, and so the time in which veterans can be expected to be seen is going to be extremely important as to whether they choose the VA or some other health care plan.

Mr. EVANS. How many VA facilities provide outpatient care today, and how long are veterans normally expected to wait for scheduled outpatient visits?

Mr. BAINE. We surveyed over 200 outpatient clinics in doing this work for you, Mr. Chairman. There are more clinics than that. I believe there are something like 350 if you count community-based clinics, the outreach clinics, and I believe there are a half dozen or so mobile clinics.

The expected time—I don't know that there is an expected waiting time in the emergency screening clinic, but what we found was that it was much longer than 30 minutes, which I would assume is about the time people would be expected to wait if they went to the doctor on a scheduled appointment.

Mr. EVANS. To compete successfully, do you think the VA needs to offer ambulatory care at more locations or outpatient clinics?

Mr. BAINE. It is our sense, Mr. Chairman, that as the VA turns its system around toward a system which emphasizes primary care, it will undoubtedly have to have some way to reach out to veterans.

Whether veterans will choose the VA system depends on waiting times for certain, it depends on how accessible they are to particular VA facilities, and it is also going to depend on what the comparative benefits and out-of-pocket costs are going to be. But our sense is that VA will have to do some outreach.

Mr. EVANS. The VFW has suggested that most VA outpatient clinics only have one examination room for each doctor, and they suggest that if you increased it to two, you might see an increase of about 30 percent efficiency for a doctor; if you had three examining rooms for each doctor, you might be able to increase it by about 50 percent. Did you look at this issue or did you find any instances where VA outpatient clinics had more than one examination room for a doctor?

Mr. BAINE. Let me ask Dot to comment on that. I believe, in my own travels in the country, that I have found some instances where there was more than one examining room per doctor, but Dot can maybe comment on that.

Ms. BARRETT. We didn't directly examine that, but in hearing comments from people, it seemed, in the seven centers we visited, most of them had only one examining room for patients. Some of the newer centers were trying to use two examining rooms per doctor, but the older units don't have the space available.

Mr. EVANS. Did you notice, or have you been able to ascertain whether that is more efficient to the extent that the VFW suggests it would be?

Ms. BARRETT. I think it is recognized in the private sector that it is more efficient to use two rooms. For example, one patient can be getting changed while the physician is examining the next patient, which allows the physician to use his time more efficiently.

Mr. EVANS. The veteran service organizations will testify today that a veteran who wants to use VA outpatient services has to be pretty persistent, first in getting a scheduled appointment, then going through the waiting lines, and perhaps even being told, "Come back tomorrow." How should VA address these issues? For example, service-connected veterans who work have quite often difficulty getting off a whole day to receive service-connected treatment. Should weekend hours or nighttime hours be considerd? The Legion has suggested working to provide lodging for veterans who have traveled a long distance.

Mr. BAINE. We have heard those suggestions being made, and those are suggestions the VA should take under consideration.

Our sense is, Mr. Chairman, that there are lots of things the VA can do operationally in the centers that they now have to improve the efficiency with which they run their ambulatory care system.

The notion of telephone networks: A veteran could call up—many of the episodes of care that people come in for are episodes of care that can be handled over the phone. VA is not making a great deal of use, for example, of telephone assistance networks, maybe in 20, 25 places around the country.

So there are some things that we think the VA can do in the system, as it is, to try to address some of the problems that the veterans groups have raised.

Mr. EVANS. My time is up, but I might have some additional questions later. Let me yield to the gentleman from Pennsylvania.

Mr. RIDGE. Thank you, Mr. Chairman.

I was wondering, when you were comparing those outpatient facilities that had a telephone network system where veterans could, by prearrangement, make an appointment to go in and visit, and those that did not, is there a quantifiable difference in terms of how long these men and women have to wait to get the service?

Mr. BAINE. There is a quantifiable difference, Mr. Ridge. The one that stands out in my mind is a medical center out in Portland which started a telephone assistance network, I think three or four years ago. Paul and I were just out there a couple of weeks ago, and the medical center director said that they are now taking about 200 calls a day for assistance to veterans, many of which would have been handled by walk-ins.

The Portland Medical Center has reduced the number of folks who walk into the emergency center by—what is it, Dot?

Ms. BARRETT. They have about 50 a day, and there used to be well over 100 before they started the telephone.

Mr. BAINE. So they reduced it by about half.

Mr. RIDGE. That seems to be a good lesson, a paradigm that a lot of the other health care centers could look to.

I presume that what is happening is that the VA is discovering when they discuss the problems with the veteran, that it is really not a crisis, not an urgent medical condition, and they can either deal with it over the phone or just set up an appointment down the road to deal with the problem. Is that a fair assessment of what the telephone communication system has been able to do?

Mr. BAINE. That is a fair assessment.

Many of the requests have to do with prescription refills that can be handled over the phone. The way that works is, there are people who receive the calls, there is a nurse to back it up, there is a pharmacist involved, and these people have access to the various physicians throughout the medical center, and they can get it done, and get it done in a relatively short period of time.

Mr. RIDGE. I have two VA medical centers in my Congressional district and a third just on the outside, one in Erie, PA, one in Butler, and the Oakland facility, a couple of facilities in Pittsburgh, and I have talked to a lot of veterans with regard to outpatient treatment, and they have complained about processing requirements, and I note that you refer to a facility that reorganized the processing requirements and again made a quantitative and qualitative difference in how they handled patients in a timely fashion. Would you care to comment?

Mr. BAINE. If you don't mind, I would like Dot to comment on that.

Mr. RIDGE. Please.

Ms. BARRETT. When we visited Dallas, what they had done was had their staff re-examine what was going on, because the veterans were standing in three or four different lines before they even got to see the physician. Through that process, they were able to short-

en waiting times down and have veterans go through the triage process within ten minutes. So they were pretty successful in shortening the process and facilitating the whole thing for the veteran. They still had a very large volume, and Dallas didn't have telephone triage.

Mr. RIDGE. So a combination of telephone triage and processing changes could go a long way to facilitating the treatment and reducing these almost interminable delays. This does not seem like rocket science, and you wouldn't think it would be too difficult for each VA medical center to set up that telephone network and have some of this triage going on.

A final question. When I talk with some of the medical personnel at some of the facilities, the change from a specialty-based delivery system to a primary care system where everybody is assigned their own physician, and hopefully will stay in contact with that physician throughout their course of treatment within the VA, was meeting with some resistance from those who were used to doing it the old way.

I mean I think it is predictable in any institution to see that inertia sometimes gets in the way of progress; they have just been doing it that way for so long, they don't care to make changes.

Did you detect any problem within personnel in resistance at any of these facilities, resistance to the changes from a specialty-based system to a primary care system?

Mr. BAINE. I don't know that there was outright resistance, Mr. Ridge, but it is quite true that the culture of the VA system is heavily founded on episodic care and care in particular specialties and subspecialties. As VA goes to a primary care system, I think some of the things that you have noted may well in fact occur.

This is a hard thing to turn around, and it is a big system. What VA is actually doing, is sort of turning the system 180 degrees—and that is going to take some time and some skill. It is quite a challenge for the VA to undertake.

Mr. RIDGE. It will take time and skill and probably patience on behalf of the service provider as well as the veteran, although I think veterans demonstrate on a fairly regular basis how patient they are, because they do wait from one to three or four hours to get these services.

So I think you are right, we need to change that culture, but you have given us some very good recommendations and very specific ideas that I am hopeful the VA will embrace in order to bring those changes about.

Thank you very much.

Mr. EVANS. Thank you.

Dave, we are going to enter Secretary Brown's response to the GAO report at this point in the record, and I would ask you how you respond to his comment that GAO's report did not address space deficiencies, staffing shortages budgetary issues, and the demand for care which "contributes significantly to certain medical centers' abilities to provide efficient services." I'm quoting him.

Mr. BAINE. Mr. Chairman, it is true that we did not address the things that the Secretary decribed.

We made the assumption going into this work that there are efficiencies—operational efficiencies—that VA could take advantage of,

and what we wanted to do was to find out if that hypothesis was correct, and it turned out that it is very much correct.

That is not to say that as VA goes to a primary care system and becomes a competing provider, that it won't have to make some adjustments in facilities and require some additional resources. But, a lot of these things can be done by shifting the resources that are already in place.

This is a $14 billion medical care system, and there are resources available. You know, some of the resources can be shifted rather than new resources being needed to address the problem, it seems to us anyway.

Mr. EVANS. Who is responsible for improving VA outpatient care timeliness, and did you find substantial evidence that better outpatient management is a top priority for the VA Central Office and officials?

Mr. BAINE. The responsibility for all medical care in VA, as you know, rests with the Under Secretary of Health's office. The responsibility of delivery, of course, is at local medical center directors' levels.

I believe that heretofore there has not been sufficient emphasis—top-side emphasis—on the ambulatory care portion of the VA health system. I think also, however, that as VA is expected to become a competing provider, the emphasis has been increasing, as Dr. Headley will, I assume, testify this morning, and VA is working very hard now to try to get a handle on how to turn this thing around.

Mr. EVANS. Are the actions they have taken and plan to take, for that matter, likely to improve timeliness?

Mr. BAINE. Our sense is that those kinds of actions will improve. They have got to. Otherwise, VA is not going to be a successful competing provider under national health reform.

Mr. EVANS. I am curious because in 1982 the VA medical center in Miami reported improved patient satisfaction and fewer drop-in visits as major benefits of a patient telephone program. Today, 11 years later, in your opinion, is the VA making widespread or limited use of patient telephone programs?

Mr. BAINE. As I mentioned before, Mr. Chairman, I think there are about 20 or 25 medical centers around the country that make some use of telephone assistance networks.

Mr. EVANS. They are doing it on their own though.

Mr. BAINE. And they are doing it on their own.

Mr. EVANS. There is no guidance or suggestion——

Mr. BAINE. To this point, that is right.

Mr. REYNOLDS. I think that probably points out the lack of central leadership.

It was a good idea in 1982. It was a good idea in 1986 when Portland started it and when some of the others did it. What they need to do from here on out is to take the best practices and replicate them systemwide.

I think that there are lots of other things that they need to identify and do. They have the solutions. They have a lot of bright people, hard working people, in the medical centers, but unfortunately there is no mechanism for sharing a lot of the good ideas, and that is really where they need to go.

Mr. BAINE. Mr. Chairman, could I make one other comment about why this might not have happened? The budget incentives in VA for the last ten years or more have been based on number of visits, number of people who show up at the door, at least in the outpatient portion of the hospital. So there is very little incentive to establish a telephone network. It costs some money to do it—to shift resources inside the medical center. There is not much incentive to do it, and when we talked to some folks around the country, particularly the medical center director at Portland, he said that he did this at some financial risk to his own institution because he was not getting paid for that, he was getting paid for people walking in the door.

So to change this is going to require a change in institutional incentives in addition to the things that Paul mentioned.

Mr. EVANS. Have you any estimates of how much your recommendations would cost the VA to implement?

Mr. BAINE. We don't have an estimate of what our recommendations would cost.

It is our sense, Mr. Chairman, that if the suggestions we have made become a part of the routine way of doing business, you know, the incremental cost of doing that is not all that much in terms of being able to monitor waiting times. That is done every day in the private sector. A large hospital health care corporation which is also going to be a competing provider knows what the waiting times are in their various facilities around their system. They know, and where they are too long they will try to do something about it.

Mr. EVANS. Can you comment on the VA's statement that 89 percent of the patients surveyed were satisfied with the promptness systemwide?

Mr. BAINE. Yes. I believe we had in our report that 11 percent of the patients who responded to VA's patient satisfaction surveys were dissatisfied. VA has turned that around and said, well, that means 89 percent of the folks were satisfied. That turns out not to be the case because in most every survey instrument there are gray areas. While 11 percent of the folks said, "We are really dissatisfied with the thing," there is maybe another 20 or 25 percent that said, "We are marginally dissatisfied," and the other two-thirds said they were satisfied or better.

Mr. EVANS. Is it possible some veterans have simply left without making a formal complaint after waiting for hours and still not receiving care? Were they included in the surveys?

Mr. BAINE. Our sense is that that happens fairly frequently. Folks will show up at the medical center, they will wait a certain amount of time, and for one reason or another they can't wait any longer, and they leave and do not go through a patient complaint system or whatever else.

Mr. EVANS. I yield to the gentleman from Pennsylvania.

Mr. RIDGE. Thank you, Mr. Chairman.

I just wanted to thank you for your analysis and the supporting comments.

You indicated before that a lot of people are talking about reinventing government, but your review of the VA delivery system indicates to me, and hopefully to the VA, that they don't have to

reinvent anything, they ought to just replicate what they are already doing throughout the VA system in isolated instances.

I mean the telephone network, the reduction in processing requirement time, those ought to be almost budget neutral, and if there is a little extra money needed, you can certainly shift the resources to do that. I think you have made a real contribution, and I want to thank you for that.

Mr. Chairman, unfortunately, I have a markup I have to get to, and I am going to try to get back because I very much appreciate this hearing and the long list of witnesses scheduled to testify. I am going to try to get back and listen to a few more of them.

Thank you.

Mr. EVANS. I appreciate your concerns today.

Dave, thank you. Additional questions will be submitted to you in writing and your written response to those questions will be included in the hearing record.

Thank you for your work.

Mr. BAINE. You are welcome, sir. Thank you.

[The questions and answers appear at p. 117.]

Mr. EVANS. The members of our first panel represent veterans service organizations. Testifying on behalf of the Paralyzed Veterans of America is Terry Grandison. Kelli Willard is representing the Vietnam Veterans of America and is accompanied by Bill Crandell. I understand this is her first appearance before any subcommittee. Kelli, we welcome you.

Testifying on behalf of the American Legion is Frank Buxton.

The prepared statement submitted by each member of the panel will be made part of the record, without objection, and you are invited to summarize from your prepared remarks.

Terry, once you are ready, we will start with you.

STATEMENTS OF TERRY GRANDISON, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; FRANK C. BUXTON, DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; AND KELLI R. WILLARD, LEGISLATIVE ASSISTANT, VIETNAM VETERANS OF AMERICA, INC., ACCOMPANIED BY BILL CRANDELL, LEGISLATIVE ASSISTANT

STATEMENT OF TERRY GRANDISON

Mr. GRANDISON. Mr. Chairman and members of the committee, on behalf of Paralyzed Veterans of America, I wish to thank you for this opportunity to express our views on VA's ability to provide timely ambulatory care services to veterans.

Mr. Chairman, at the outset, I believe that most of us here today would agree that this issue is not novel. The coauthors of the independent budget over the years have strongly questioned the inadequacy of VA's outpatient capability and the excessive waiting times veterans must endure to obtain appointments for routine services as well as for certain specialty services.

PVA concurs with the findings and recommendations of the recent GAO and IG reports. PVA also recognized that VA has made efforts to adapt new outpatient models. However, this process has been encumbered due to institutional, budgetary, and administra-

tive roadblocks. Nevertheless, now is the time for these problems to be resolved in a swift and straightforward manner.

The health care reform plan proposed by the administration gives the VA health care system the ability to survive. However, this opportunity will not be given gratuitously. VA can only survive if it is able to compete successfully with the private sector over patients, cost, and quality.

The Clinton proposal would give veterans the choice to use the VA or to go elsewhere for comparable benefits. That choice will undoubtedly be made on the individual's assessment of the quality of the services his or her chosen provider can offer. If VA does not measure up in an individual veteran's assessment, that veteran will seek care elsewhere.

Based on our studies, PVA has found that patients tend to make their determinations as to quality of health care not so much on the qualifications of the provider but on how they are treated when they seek medical care. Simply stated, reasonable waiting times, courteous staff, and pleasant surroundings equate to quality care.

Moreover, waiting times were the clearest indicator of the effectiveness of an outpatient operation. Waiting times, likewise, are the clearest indication of patient satisfaction or dissatisfaction with health care services and a health care system that provides those services.

Mr. Chairman, that concludes my testimony. I will be happy to respond to any questions you may have. Thank you.

[The prepared statement of Mr. Grandison appears at p. 59.]

Mr. EVANS. Terry, thank you.

Before proceeding with this panel, the Chair is very pleased to recognize the gentlewoman from California, Maxine Waters.

OPENING STATEMENT OF HON. MAXINE WATERS

Ms. WATERS. Thank you very much, Mr. Chairman.

I am indeed very pleased to participate in this important hearing this morning, and I would like to commend you on your leadership in bringing this matter and other such matters affecting veterans before this subcommittee.

I often hear complaints from veterans concerning delays in receiving services from the VA. Veterans tell me about sitting in crowded waiting rooms all day long to see doctors for something that took 30 minutes to treat. Veterans also tell me about having to wait sometimes four to six months to get appointments. They tell me about lengthy delays in getting their prescriptions filled, and the list goes on and on.

Mr. Chairman, I am sure that you and many of my colleagues on this subcommittee hear many of these same complaints. It is very frustrating for me, and I know for you, to keep hearing these same complaints over and over, to come to these hearings where we discuss these problems, yet conditions at the VA don't seem to get any better.

I know that these problems are not new. These types of problems have been long standing at the VA, and I commend the Secretary and his staff for initiating new approaches to correcting some of the ills that have afflicted the VA for so long.

I hope the VA will continue that approach and today we will hear not excuses or explanations for why these problems exist, but aggressive techniques that the VA has implemented to correct these delays, and that is what I want to hear. That is what I look forward to hearing from the VA.

Our veterans deserve to know that when they seek medical care from the VA, that care will be made available to them in a timely manner.

I look forward to my continued work on the subcommittee and with the service groups represented today as we seek to be advocates for veterans in making sure that they receive the best services possible.

Thank you for allowing me to enter my statement into the record, Mr. Chairman.

Mr. EVANS. We are glad to enter your statement, and we appreciate your leadership on these issues.

We have also been joined by my colleague from Illinois, Congressman Luis Gutierrez, and the Chair will now recognize him for any statement he would like to make.

OPENING STATEMENT OF HON. LUIS V. GUTIERREZ

Mr. GUTIERREZ. Thank you very much, Mr. Chairman.

I am very glad that we are asking this particular question today: Are veterans forced to wait too long to receive outpatient treatment? I am glad that we are taking a look at how the VA works on a really practical basis.

Very often in Congress we think in very broad perspectives. We look at macroeconomic budgets for instance, but sometimes it is hard to see how those figures actually relate to the individual man or woman who are simply trying to conduct their life and get health care they need.

It is a question that encourages us to put ourselves in the position of a veteran who is hoping to use the VA. It puts us in their shoes. How does it feel to wait all day to see a doctor even if you have an appointment?

Waiting times are not simply a question of convenience. After all, our goal here is not simply to see that we can get our veterans a little bit more free time. Let's remember that veterans are people who hold jobs and have families, and if you have to spend all day waiting for health care, you are not going to have time to fulfill your duties to your coworkers or children. And, more importantly, waiting a long time is harmful for any veteran who has a serious health concern. It is not like getting your car fixed. Maybe you can wait on that. Here we are talking about getting your health looked at, and in that, there is no excuse for unnecessary delays.

Very simply, Mr. Chairman, the VA's patients should not have to have patience. They should get the care they need quickly and effectively, and let's keep in mind, as long as they are talking about appointments, the VA itself has an appointment, the VA has an appointment with health care reform, and if we want to keep the VA viable and competitive, we are going to have to solve the problems inherent in the current system. That is why I am interested in hearing the comments of the witnesses today so that we can move forward to a VA health system that works even better.

Thank you, Mr. Chairman.

Mr. EVANS. Thank you. We appreciate your work as well, Luis. Frank, you may proceed whenever you are ready.

STATEMENT OF FRANK C. BUXTON

Mr. BUXTON. Good morning, Mr. Chairman and members of the subcommittee. Thank you for this opportunity to present the views of the American Legion concerning the provision of outpatient care at VA medical centers.

Mr. Chairman, a most familiar sight in a VA clinic and the most frequent complaint that our field service representatives hear are about the crowded waiting rooms and the long waits for care in the outpatient areas. There are not only long waits to see a practitioner once the patient gets to the VA, but there are frequently long waiting times for an appointment to come to the VA, especially for subspecialy care.

The first response is to blame a lack of resources for the inadequate space and insufficient numbers of physicians and nurses, and this is indeed placing blame in the right spot. The case loads in many VA clinics have increased without a commensurate increase in resources.

However, the root causes of these problems do not always lie directly with the lack of dollars. According to the IG, managers at the facility level often do not place an emphasis on ambulatory services simply because they have not made themselves aware of the horrendous problems at their own institutions or are still functioning with an inpatient mind set.

VA doctors and researchers do great things for patients. They have developed excellent programs and have done outstanding research. One thing the VA has not learned, however, is how to function as an efficient ambulatory care delivery system under the primary care model.

An American Legion proposal to improve veterans health care reinforces the concept that ambulatory care services are less expensive to administer and are essential in the delivery of holistic medicine.

One of the major faults of superspecialization is that the patient is often looked at through the eyes of care giver only in terms of the specialty treatment. Veterans, as do all patients, need to have a full continuum of care available to them in order to receive quality care.

Mr. Chairman, the most effective way to assure quality continuum of care to the veteran is through eligibility reform as the first in a series of changes. Whether that reform occurs now or during the implementation of the administration's health care reform plan, eligibility for a full continuum of care for veterans must occur soon.

Mr. Chairman, the administration's health care reform plan, which is a modified managed competition model, would make it necessary for VA to compete with the private sector system for veteran patients. In order to accomplish this, the VA will have to have adequate resources to improve outpatient facilities, adequate staff to care for their customers, and, the most important of all, be allowed to move into a managed care/primary care model of health

care delivery. Extended waiting times for care can make the VA a very unattractive option under competition.

The VA needs to become a master at the delivery of ambulatory care and noninstitutional services in the most efficient forms imaginable. Realistic funding, sensible scheduling of appointments, and development of a primary care model, including the use of nurse practitioners and physicians' assistants where appropriate, and the facilitation of overnight facilities for outpatients when necessary, with the appreciation that veterans sometimes travel hundreds of miles for their appointments and simply cannot return home the same day, all of these are in urgent need of implementation.

Mr. Chairman, the American Legion recently participated in a VA seminar at Tampa, FL, at which clinical and administrative leaders of the VA and consultants studied the problems associated with the VA's provision of ambulatory care and the formation of primary care teams. This group made a series of strong recommendations to the Secretary regarding methods to improve these services. It is important that these recommendations be carefully analyzed and critical resources be allocated to implement them post haste.

Mr. Chairman, the VA can no longer operate in an expensive inpatient care model, but must move forward now to the improved provision of health care on an ambulatory and a primary care basis. We, as an organization, are prepared to do what we can to make this happen.

From all our observations, everyone agrees that the delivery of ambulatory services in the VA must undergo change now. We know what is wrong. We have expert recommendations to fix it. Let's move ahead with it.

Mr. Chairman, that concludes our statement.

[The prepared statement of Mr. Buxton appears at p. 64.]

Mr. EVANS. Thank you.

Kelli.

STATEMENT OF KELLI R. WILLARD

Ms. WILLARD. Mr. Chairman and members of the subcommittee, VVA appreciates the opportunity to present views on the timeliness of VA outpatient care this morning. This is one of the central consumer friendliness problems that VA must address to be a viable competitor in a national health system. We commend you, Mr. Chairman, for holding this hearing.

Arguments can certainly be made that VA provides quality care, but toils under the close scrutiny of negative press. But the determining factor in whether VA will sink or swim in a competitive environment is how veteran users feel about the VA, not the statistics VA purports about accreditation and mortality rates comparable to the private sector.

Excessive waits for scheduled outpatient appointments are a major contributor to veterans' negative perception of VA health care. Secretary Brown's comments before the House and Senate Veterans' Affairs Committees on this issue of timeliness indicate that the VA finally realizes its mammoth bureaucracy is supposed to operate for the veteran users.

Recently released GAO and VA Inspector General reports reveal exactly what veterans have said all along. This problem is a deterrent for veterans seeking care. Eventually, many give up on the VA and make private expenditures to see a local provider or, worse yet, they forego needed care.

Granted, VA does have staffing problems resulting from budget shortfalls. VA management can improve this problem, aside from simply adding staff. Positive role models cited in the GAO report are evidence that ingenuity can improve services.

First, VHA should provide facility directors with effective methods of measuring waiting times. Many directors do not currently evaluate this important factor of patient satisfaction and therefore are not aware of the problem and thus don't take corrective action.

Subsequently, Central Office should establish and enforce timeliness goals. Timeliness varies widely from clinic to clinic because facilities set their own goals, are at their own discretion of monitor compliance, and often fail to do so.

Clinics should use appointment schedules to manage work load. Many currently do not. Overbooking of appointments in anticipation of no-shows is another cause of delays identified by the IG. Reminder calls would cut down on these no-shows.

We all hear stories from the field of veterans who miss outpatient visits because they forgot appointments scheduled six months prior. Scheduling should be convenient for the veterans.

One VVA member offered this example. After waiting several hours for an exam, the doctor directed a nurse to schedule a test at the patient's convenience. The phrase didn't compute for the nurse. The doctor repeated it. After the test was scheduled, as our member walked toward the elevator, he heard the nurse muttering, "At his convenience? At his convenience?"

Fortunately, recent statements by Department officials indicate that this attitude is changing. VA now admits the need to address its consumer friendliness image and does not simply complain of inadequate funding.

Another factor which delays VA outpatient visits is of course the eligibility checks which verify the veteran's service record, disabilities, and income. We realize the impossibility of implementing eligibility reform without national health reform. Veterans currently unable to obtain private sector care would flood the VA.

The Clinton health care plan seems to give service disabled and low-income veterans an entitlement to care at the VA. Certainly the plan views overall health care as a right and entitlement for all Americans and does make special provision for those who have sacrificed personal safety while serving in the armed services.

We are hopeful that the VA system will compete successfully under health reform. The President's plan provides all the tools necessary for it to swim. But someone needs to ask, what if the VA sinks? Then what becomes of the veterans with special health care needs for which the private sector has not been forthcoming, such as PTSD, prosthetics, and spinal cord injuries? Will service-connected veterans still be able to get cost-free care, and how can this be provided without the VA?

We recommend that Congress consider establishing a service-connected veterans health care entitlement just as the elderly and dis-

abled are entitled under medicare. This is important to ensure that this Nation upholds its commitment to veterans whether the VA prospers or goes the way of the Canadian system, and it is important that this be done along with national health care reform because if, ten years down the road, the VA system no longer exists, it is going to be impossible to do it at that point.

Mr. Chairman, this concludes my statement.

[The prepared statement of Ms. Willard appears at p. 70.]

Mr. EVANS. Thank you very much. We appreciate all of your suggestions and your testimony today.

Two members of this panel mentioned eligibility reform. I don't think that is probably likely to happen until we adopt some kind of national health care reform. Unfortunately, that may not be for a while. How it will unfold is still unclear.

As we move to a system of national health care and if the VA is to be competitive, it will be a system open to all veterans, not just service-connected or low-income veterans. That is our understanding of what the President will be proposing.

I think all of us view the coming changes from a local perspective, how it will affect veterans in our district. If the VA, for example, isn't providing timely care at the Peoria or the Bettendorf Outpatient Clinics that we have, if VA doesn't establish a clinic in Quincy, as we have examined and encouraged, and if VA doesn't have good standards of timeliness, veterans are not going to participate. I think that is very clear, and that is probably true for my colleagues from Chicago and L.A., as they are facing the same kinds of problems. I think that is how we will make decisions on national health care.

As we look at this issue, VA can adopt some of the suggestions from the GAO, and can also look to other suggestions—for example, the one Frank made in terms of providing overnight lodging. There are veterans in Quincy, Illinois, who have to travel to Iowa City. It is about 125 miles. If they are ill and can't drive back following their appointment, they are simply not going to use the VA health care system.

We appreciate your testimony. I will yield to my colleagues for any questions or comments they might have.

Luis.

Mr. GUTIERREZ. Thank you very much, Mr. Chairman.

This is just to the panel. The Inspector General's audit said that at the four VA medical centers that they studied, the top officials were not aware of excessive outpatient waiting times because their facilities had not established a procedure to monitor that information.

I am concerned that this indicates a fairly alarming degree of detachment on the part of those officials. In other words, I have heard that many veterans wait for hours in waiting rooms for an outpatient clinic. If that is the case, I that someone that works in the hospital would come across at a different point in the day—they would seem to pace around the floor or look nervously at the clock.

Obviously, that worries me very much, and I would like to see if the panel could just reiterate ways that we could connect the top-

level staff and some kind of monitoring system, if those monitoring systems exist in other hospitals.

Mr. BUXTON. If I may, Mr. Gutierrez, there are two factors that we can determine. One of them is the way that the VA has been reimbursed in the past. They are reimbursed primarily on the basis of inpatient care.

Before this hearing, I was speaking to Colonel Brickhouse who has extensive military medical experience, and he said that for what it costs them for one inpatient they could treat 33 outpatients in a study that they did. I think that probably holds true in the VA as well.

So we have here, because of the way they were reimbursed, a desire to admit patients even for things such as colonoscopies and cystoscopies when in the private sector that is ludicrous.

The other issue is the mind set. Aside from the reimbursement, there is and has been over time an inpatient mind set. I was recently involved in a study out in the Midwest where we talked to the private sector about how they perceived the local VA and said, "What do you think of the VA?" and they said, "Oh, you mean the old soldiers home on the hill."

Many people perceive the VA as an inpatient facility, and I think that whether the managers of that facility like it or not, they have to change, and at the recent seminar in Florida we saw a lot of indication that they are willing to change because they know that means survival in many cases.

So I think that those two issues—one, the finance has to change; and the other is, that they need to change the whole mind set of the people that administer these programs so that they can, without a doubt, understand that this is the way we are going, a primary care model with expansive outpatient facilities available to the veteran.

Thank you.

Mr. GRANDISON. Congressman, I also have two comments.

First to your first statement, we agree that there is a gap between the administrators and the physicians and other providers of the care on the line. I think there is a lot of talent in the VA, but if this gap is not filled, there is no coordination for physicians and other staff to inform and advise, "Well, this is the best thing, and we think this idea can work if we implement it."

So basically what it does is deny innovative change, because if you don't have the layers of command interacting on a regular basis, you are not going to be able to come up with great ideas or innovative ideas to provide timely care. So I agree with that statement wholeheartedly.

Secondly, just echoing Frank's comments. The existing eligibility criteria in the VA favors inpatient care. There has to be a shift. PVA has urged this for years. There has to be a shift from inpatient modalities of care to outpatient modalities of care.

The private sector has followed this trend for years now. The examples are out there. VA must take the cue and actually step out there and do it, and basically the VA is in a unique position to do a lot of changes for the betterment of veteran care, and these things do not require a legislative mandate, these things can be done in house, but there has to be cooperation and cordination

within the VA, and these are not new issues and they are not severely daunting issues.

That is all.

Mr. GUTIERREZ. Thank you very much.

Mr. CRANDELL. I would just like to add that I think Frank Buxton is absolutely right in linking mind set and management. If any high school cafeteria in this country set out to become a French restaurant in the evenings, they would have to do a lot more than spend some money on tablecloths and tuxedos, they would really have to change how they do business.

Mr. GUTIERREZ. That is a very good point. I am going to make sure we write it down. I might not credit you later on when I use it in a speech or something. So if you read it in some newspaper, "Congressman Gutierrez was very eloquent and cute as he referred"—No, I am not running for President, never. So you don't have to worry about me on that.

The other thing, I just want to finish up by saying to Ms. Willard: I don't know why, you lit a light bulb with the entitlement as we look at health care reform within the VA, and you delineate practically what we have heard here about how it is veterans are going to be treated, to maintain that entitlement there.

So we will continue, because I share with you your view that if it doesn't keep up, it is going to sink, and if it sinks, and it is not the responsibility of the veterans that the system sinks, it just simply wasn't there and wasn't competing, and given sometimes the backward thinking of a lot of people, including Members of Congress who can't seem to get it through their heads that, you know gynecological care is not a special care and a special preference just for women—how could we treat them specially?—when they begin to understand things like that, because, you know, I know a lot of veterans who are colleagues of mine, both on this committee and in the House, who think that is special care. I just wonder if they can survive later on with those kinds of attitudes.

So I like the idea. I had my microphone on. Fortunately, I was whispering to the gentlewoman from California, I blurted out, "That is a good idea." I am really happy you brought it up today.

Ms. WILLARD. Great.

I just want to state for the record that VVA is very hopeful that VA will continue to exist to serve veterans' health care needs. And we are encouraged by some of the recent moves VA has taken in that direction—moving toward the veterans service areas and planning to implement a more managed care approach.

It is just that all of you need to be thinking about what if VA doesn't compete effectively, because it is going to be up to the veterans who actually use the system throughout the country whether the VA survives or not.

Mr. GUTIERREZ. Thank you, Mr. Chairman.

Ms. WATERS. Mr. Chairman, I would like to say to Ms. Willard that I and most others on this committee support the system and would like to see it improved and expanded. But I will not continue to support this system unless it becomes a system that does not discriminate against women, and unless it becomes a system that will provide some very basic health care services, then I cannot in good conscience continue to support a system.

Yesterday was an interesting moment in this committee when Congressman Gutierrez made an impassioned plea for gynecological services to be included in a real way and was rejected.

Following that, we had another piece of legislation, even though it did not relate directly to providing health care services, which started out to correct some of the wrongs of the system that do not allow for health care coverage for unmarried spouses of deceased veterans, and it was rejected.

So I am going to work very hard for a period of time to make the system a good, comprehensive system, but at some point I am going to quit, and then I am going to turn, and then I will be a part of dismantling a system that discriminates and talk about folding it into the larger health care system.

Ms. WILLARD. We agree with you that it is very important that VA provide equitable care for male and female veterans. As part of its being able to be competitive, it is going to need to be able to provide comprehensive services. That includes everything available in the private sector.

I know I, for one, wouldn't choose to go to the VA if I can't have all of my health care needs taken care of there. There is also a very real potential that veterans' dependents are going to be accessing care, if not at the VA, through the VA, at the Secretary's discretion under the President's proposal. I think adequate care for women is going to be a very real concern for younger veterans who do have family members.

So we were supportive of Mr. Gutierrez' amendment, and we were very sorry to see it go down.

Mr. EVANS. I might add that in his impassioned address he was also accused of trying to bring eligibility reform as far as women veterans were concerned as well.

So we appreciate your advocacy, and thank you very much.

I assume that all of you are in agreement that VA should provide more primary care kinds of services in outpatient clinics and that will help reduce the long delays in the specialty clinics. We are all in agreement on that issue?

Ms. WILLARD. Definitely.

Mr. CRANDELL. Yes.

Mr. BUXTON. Yes.

Mr. EVANS. Thank you all very much. We appreciate your testimony.

Mr. EVANS. The members of our next panel also represent veterans service organizations. Michael Brinck is appearing on behalf of AMVETS; representing the Veterans of Foreign Wars is Dennis Cullinan; and testifying on behalf of the Disabled American Veterans is David Gorman.

As you get assembled, we will tell you that your entire statements will be made part of our record, without objection, and you are invited to summarize your prepared remarks.

Michael, we will start with you.

STATEMENTS OF MICHAEL F. BRINCK, NATIONAL LEGISLATIVE DIRECTOR, AMVETS; DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR OF MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS; AND DENNIS CULLINAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE U.S.

STATEMENT OF MICHAEL F. BRINCK

Mr. BRINCK. Good morning, Mr. Chairman. Thank you, and I will summarize. This is an important hearing.

AMVETS has reviewed the recent studies of access delays done by GAO and the Inspector General, and while the findings quantify the frustrations often felt by veterans, there is really nothing newsworthy. AMVETS and our other organizations here at the table have been testifying regularly to the long waiting times. We concur with the findings in the IG study.

Overbooking, block scheduling, insufficient appointment time allotment, lack of adherence to schedule priorities, and late arrival of physicians would seem to be relatively easy things to fix. But so are monitoring average waiting times and periodically reviewing the scheduling practices of local managers.

The most intriguing thing I found was that the finding by GAO that a facility had reduced waiting times by 80 percent by reorganizing processing requirements really begs the question, why were all other similar facilities not directed to implement these changes? Isn't that the job of any system with a centralized policy development and decentralized policy execution process? Why does it take so long for a good idea to get wide application? Why is there so much diversity in the operational policies of VA medical centers? What is it about the system that seems to defy any level of standardization?

Mr. Chairman, AMVETS would like to make one final point. I am afraid what we have here today is a continuation of a long series of hearings devoted to VA bashing. In the coming competitive atmosphere, it will be necessary to continue oversight to ensure effective use of taxpayer dollars. But it is time to begin emphasizing what is right with VA medicine or VA will not be able to compete. The Nation will lose a valuable health care asset, and all of us here bear a share of the responsibility for that demise.

If the members of this committee take nothing else away from today's hearing, AMVETS hopes you will remember that Congress and the Administration are the only ones who can make this work. In addition to the operational changes that have been mentioned by both the Members and those who are testifying, it takes money, and you and the Administration are the only ones that can provide these resources. In a sense, the buck starts here.

That completes our remarks, and I will wait for any of your questions.

Thank you.

[The prepared statement of Mr. Brinck appears at p. 81.]

Ms. WATERS [presiding]. Thank you very much, Mr. Brinck.

Mr. Gorman.

STATEMENT OF DAVID W. GORMAN

Mr. GORMAN. Thank you, Madam Chairwoman.

I would think that my message would be to impart one hope as we leave here today, and that is that the VA recognizes, as well as all of us involved and committed to preservation of the VA system, that all of the things that are being said now can't be prefaced by saying we need to talk about and we need to think about, but rather, I hope that we leave here with a message that we need to do something and something needs to happen now. If not, this window that I think the President has opened for the VA to allow the VA to flourish as a system is going to be slammed shut, and the boat that needs to be turned around, as Mr. Baine referred to it, is a big one, and the time to do so is running out, it is very short.

I think of the adage, "Build it and they will come." I believe VA has built a system, and they are going to be able to put in place the most state-of-the-art facilities, excellent care providers and all that goes with it. However, if veterans can't get in to see those providers and can't get in to use those facilities, then they are not going to come to the VA. And things need to happen, and they need to happen, as I said, now.

A lot of the things that we want to talk about have been mentioned, and I don't want to be repetitive, although I am afraid I probably will be, things such as simply accessing the system.

Mr. Gutierrez, out in Chicago, the VA is going through an interesting process of networking within the facilities in the Chicago area. To me, there is little sense in why a veteran who needs say an orthopedic clinic and walks into Westside and is told that it is a three-month wait in that facility for an orthopedic clinic, why someone can't punch up the computer and find where the next available orthopedic clinic is in that network of facilities and refer the veteran there. That doesn't happen. It is all kept in house, and, as a result, veterans wait.

I think, too that what needs to happen perhaps not from a national perspective of VA's Central Office, but rather from the local facility perspective. By that I mean directors have to be held accountable. There are things that both the IG has found and the GAO has found that tend to make us believe that management is asleep out there as far as some things that are important, and that is delivery of services to veterans; that is what they are there for. It is a system that should be directed toward what is good for veterans and not what is only good for the system.

VA medical center directors are paid a decent salary. They should be out there making decisions and implementing procedures that allow veterans to be seen in those clinics in a timely manner. If Portland can do it, why can't the rest of the system be able to do it? Why can't those successful programs be replicated?

There are a lot of issues. I think there is an opportunity now, and within the next week the VA is having their annual senior management conference here in Washington. I think the directors, as they come in town on this wave of reform, need to again hear that message that we need to do something now; it needs to be done today, and it can't wait. To access the system is a key. To extend evening hours, operating hours of clinics, to operate clinics on weekends when veterans can access them are key.

As Mr. Baine said in the GAO's testimony, to reallocate some resources is easily done, and it can be done, and it should be done if that is going to allow veterans to be seen and not the stereotype of, "We can't do this." It needs to be done, and it needs to be done now.

Mr. Chairman, with that I will stop, to thank you, again, for having this hearing and for again trying to bring to the attention of everyone involved with VA issues, and especially the VA, the critical need to move forward and to move forward immediately.

Thank you.

[The prepared statement of Mr. Gorman appears at p. 85.]

Mr. EVANS. Thank you.

Dennis.

STATEMENT OF DENNIS CULLINAN

Mr. CULLINAN. Thank you, Mr. Chairman.

I will also extract from my written statement. I also want to extend to you the thanks of the VFW for holding today's hearing and for inviting us to participate.

VFW has long been a supporter of improved provision of outpatient care by VA, and we see it as being especially urgent now in the face of the burgeoning aging veteran population and, of course, national health care reform. That is a theme that has been repeated over and over today.

As you know from our written statement, the VA supports the GAO findings and recommendations to make certain in-house improvements in operation and procedures. We do note, however, that by definition that the GAO report only addresses the available resources that have been provided to VA, it does not go outside of that. We believe additional funding and provision of additional FTEE also need to be talked about.

Fortunately, the VFW has a nationwide network of service officers and field representatives who have a day-to-day intimate acquaintance with the operation of VA, and from that I would like to provide some of the VFW's views.

As has been already stated today, oftentimes it is not a matter of weeks, but of months before an initial clinical appointment can be made. If the veteran is fortunate enough to make it that far, his problems are far from over. Six to seven hour waits to see a doctor are far from unusual, after which times additional long waits in lines at VA pharmacies and for additional specialty care are also the norm.

We would point out that this, in fact, constitutes the denial of care to many service-connected veterans who work for a living. These individuals can't take the day off from work to go get the VA care to which they are entitled, and we think this is just a tragedy and plain wrong.

The reasons for this are many. Years of inadequate funding and inadequate provision of FTEE start our list. Additionally, the VA's physical plant is old. Over half of its medical facilities are over 50 years old, and they were built and designed with the provision of inpatient care in mind, and they are ill suited for outpatient care.

Continuing, there are outdated procedures. This is amply illustrated in the GAO report. One VFW example: There was a study

done a year and three months ago at the Big Springs VA Medical Center in Texas, and it was discovered there that from the time a veteran set foot in the hospital for an outpatient visit and then cleared the premises, over 200 steps were involved. Now it is hard for us to believe that all 200-plus of these steps were necessary or even a good idea with respect to the provision of care. This is the sort of thing which needs to be reformed within the system.

There are other factors as well, there is a poor utilization of available personnel. What little limited personnel that VA has, they are tied up with things like paperwork, waiting for records to be provided, and so forth. And a startling realization is the improper or inadequate provision of space.

VA, in contrast with the private sector, only provides its physicians, its outpatient care physicians, with one examining room. You contrast this with the private sector where there are three or four of five rooms available, it is clear why VA has such a hard time taking care of its veteran patient work load.

In the private sector, a doctor busies himself with physician-specific duties while his LPN's and nurses and other support personnel take care of the other detail, everything from record keeping to checking blood pressure. This is something that can't be remedied, as we understand it, without the provision of additional funding so that VA's existing facilities can be reconfigured. They have got to build a few extra examining rooms, and you need the additional support personnel to book this up.

Our in-house estimate is, if you provided each VA doctor with two examining rooms instead of just one, you could improve his work load by 30 percent. If you give him three rooms instead of just one, we can increase it by 50 percent. This is something which should be looked at immediately.

It has also been mentioned here—and I will just reiterate this point—it is a desperate situation, and especially in the face of national health care reform. VA is about to be expected to compete with other large for-profit providers in the private sector, and they are ill prepared to do so. We have testified to this extent in the past. It has to do with the question of image—VA oftentimes has gotten a bad rap and so forth in the media—and it has to do with the fact that there are problems within VA, and there is the additional problem of attitude.

It has been mentioned over and over here today that when a veteran attempts to access a VA facility to receive care, oftentimes he is not treated as the valuable health care consumer that he is, but rather as a supplicant at the altar of the bureaucracy, and this is the sort of thing which has put many veterans off from seeking VA care, those who are entitled to it now, and it is certainly something that will limit, in fact could absolutely destroy, VA's ability to compete with the private sector in the face of national health care reform.

Mr. Chairman, I see my time is about expired thank you.

[The prepared statement of Mr. Cullinan appears at p. 92.]

Mr. EVANS. Thank you, Dennis.

We have been joined by the gentleman from New York, a very active participant in our hearings, and I would yield to him for any opening statement he would like to make.

OPENING STATEMENT OF HON. JACK QUINN

Mr. QUINN. Thank you, Mr. Chairman.

As almost the ranking Member now today, I feel honored to be here with all of you and join you.

I have read some of the statements already. I was detained a few minutes getting here. But I think this is no surprise, some of the testimony—almost all of the testimony that we will hear.

In fact, I come from Buffalo, NY, in the western end of New York and just this past week, the end of last week, received a letter in the mail. It was a letter to the editor of a newspaper next door to Buffalo, NY, and a Buffalo New Yorker sent it to me about having an appointment that was 250 miles away.

He went the night before to be there, got a hotel room at his expense to see the doctor the next day, only to be told to come back tomorrow. The letter is here. I appreciate being here and your work, Lane, and all the other Members on this timely topic.

Mr. EVANS. Your statement and the letter itself will be entered into the record.

Mr. QUINN. Thanks very much, I appreciate it.

Thanks for your testimony.

[The prepared statement of Congressman Quinn, with attached letter, appears on p. 51.]

Mr. EVANS. Let me first thank you, Dennis.

Your statement referred to a study, possibly a GAO study conducted at a Texas VA medical center. Can you provide us any additional information regarding this study?

Mr. CULLINAN. Actually, yes, I believe it was a GAO study. It was tied in with the total quality management concept. It was something that was undertaken locally as well. I don't know that it was GAO driven, but the hospital made a determination, in keeping with the total quality management concept, that they had to improve the way things were done. So that is what they started looking at, is, how can we speed things up? And lo and behold.

In fact, our chief field rep indicates that he thinks it was something along the line of 235 steps involved. They have improved since then, but to what extent I don't know.

Mr. EVANS. My question is, do all of you agree that we have to shift from specialty care to some extent, where it is appropriate, to a primary care model?

Mr. GORMAN. Absolutely, Mr. Chairman.

Mr. BRINCK. Certainly.

Mr. CULLINAN. Yes, Mr. Chairman.

Mr. EVANS. All right.

Let me yield to the Congresswoman from California for questions.

Ms. WATERS. No questions, Mr. Chairman.

Mr. EVANS. Mr. Gutierrez.

Mr. GUTIERREZ. Thank you, Mr. Chairman. Thank you very much.

This question is for the panel. I have seen a copy of the letter that Secretary Brown's office wrote to the General Accounting Office on October 5, 1995—that is when they received the letter. After the GAO released its very informative and detailed report, the Sec-

retary wrote that he agrees with the GAO that the VA needs to improve under managed competition.

But then on the very first page of the letter, it seems as though the VA is placing the blame on the veteran and forcing the veteran to change his or her own habits rather than the VA changing their own. For instance, the letter says that the VA staff will advise veterans of the importance in keeping their appointments and the consequences of failing to show. The letter goes on to say that a veteran should learn to contact the hospital if they are not going to be able to show up for their appointment.

It appears to me, based on these points, that the VA thinks that it is the veteran's responsibility to make sure things are easier at the VA, and yet I always thought it was the VA's mission to ensure the VA not look the other way.

What are your impressions of the VA's response to the GAO report? Do you think that the VA appears to be shifting responsibility on to the veteran?

Mr. Cullinan?

Mr. CULLINAN. In the VFW's view, it is clear there is a responsibility on both sides, but it is also clear to us that the bulk of the problem lies with VA. It is no wonder that a veteran will on occasion miss an appointment if he knows that he is going to get there and perhaps have to wait six or seven or eight hours or even be told that he has to come back the next day.

Clearly, the problem is with the VA's procedures, the lack of certain resources, everything from support personnel for the physicians to space, the number of examining rooms that we mentioned earlier, and not with the veteran. That would certainly be the wrong slant to put on any undertaking to improve the provision of outpatient care by VA.

Mr. GORMAN. I think that the responsibility of all of us who use health care services, whether it be in the VA or elsewhere, we have to take that responsibility. Some of these skyrocketing costs and the runaway health care inflation rates are due to that. So in a sense I think the Secretary is correct.

I think though, again, if I remember his letter correctly, also he relates a lot of things to, you know, the VA's strategic plan is moving toward a direction of managed care which will move toward a direction of primary care in the VA, and that is a lot of steps to get to a place where we can easily get to today.

A telephone system in the VA may cost some dollars, but so what? I mean if that is going to help and if that is going to alleviate a lot of problems, as GAO has found it does, then it should happen and those dollars should be reallocated.

But a lot of these things as far as waiting times can be done now simply by administrative fiat if they so choose to do it, and it is that mindset that has been talked about that, we can't do it because we have never done it this way, and we have got to form a group to look at this or a task force or a project office or whatnot, whatever they want to call it, is not going to make it any more, because by the time they form it and look at it and decide to do something, it is going to be too late. So the things that can be done and are recognized that can be done have to be done, simply.

Mr. GUTIERREZ. Let me just finish by saying that we are going to be in Chicago, Mr. Gorman, on November 6, and the second panel that we have coming are the four VA hospitals. They are going to come together, and we are going to begin our discussion about how they are going to coordinate the efforts that you talked about earlier. So I look forward to that hearing back in Chicago.

Mr. GORMAN. If I could add a comment, I think that is a very feasible way to proceed for the VA, to try to pool their resources in areas where they can, and try to combine resources, which will cut down on some of these issues we are talking about today. It may save some costs, but, more importantly, it is going to provide a higher quality of care to the veteran patients. So I think we are supportive of a move in that kind of a direction.

Mr. GUTIERREZ. I just wanted to let you know that we will have that hearing on Saturday, the 6th, and I certainly look forward to listening to them about how they are going to coordinate, and they are very excited apparently in Chicago and very proactive in terms of getting this thing done. Maybe we will have better information for the next hearing.

Thank you, Mr. Chairman.

Mr. EVANS. The hearing in Chicago will be very important as we examine the issue of pooling resources. We also ought to explore, in larger cities, having more outpatient clinics available in areas that are far away from the VA hospitals and not very accessible. These will be important issues we will be addressing.

Congressman Quinn.

Mr. QUINN. Thank you, Mr. Chairman.

Mr. Gorman, you mentioned just a minute ago that a phone system—it seemed that you were talking about something in earlier testimony to Mr. Gutierrez's question. Could you help me with that a little bit?

Mr. GORMAN. I will try.

The GAO indicated that if there was a telephone system set up where veterans could call into the facility and schedule clinics in primary care clinics as opposed to specialty or subspecialty clinics, that the way it is right now, it causes a bottleneck and a lot of congestion at certain times during the day when all these veterans converge in clinics and the staff just can't handle it. And there was some talk by the GAO also about simply renewing prescriptions, which can be done in large cases over the phone, instead of a veteran coming in, waiting whatever period of time he or she has to wait to see a doctor simply to get a prescription refilled.

Mr. QUINN. So what you are saying is to unclog the system a little bit, some of this work could be done over the phone, especially in some rural areas before they take a 90- or 100-mile trip in.

Mr. GORMAN. Exactly, and I am afraid I can't recite the numbers that GAO has found—you know, the waiting time and the number of patients that are averted to be seen during that—but it is a positive thing to be done, and if one facility is doing it or a handful is doing it, the rest should be doing it.

Mr. QUINN. You know, in my own experience just before I came up here—I am a freshman Member—I was a town supervisor in a small town near Buffalo. We had a problem with senior van service, Mr. Chairman, where our residents had to call a county num-

ber to try to get a ride, and we took that over ourselves and had them call us, and it saved waiting and appointment time and everything. It seems to make good sense.

Thank you. Thank you, Mr. Chairman.

Mr. EVANS. Thank you.

Thank you very much for your testimony today. It has been very important to us.

Mr. EVANS. Dr. Kenneth Klotz, Al Gavazzi, and Steve Trodden will be our next witnesses.

Dr. Klotz is the Associate Chief of Staff for Ambulatory Care and Assistant Chief of Staff at the Roudebush VA Medical Center in Indianapolis. He also serves as President of the National Association of VA Physician Ambulatory Managers. He is presenting his personal views today and is testifying before the committee for the first time.

Al Gavazzi is a service-connected veteran and a former VA employee who served as director of the VA Medical Center in Washington, DC, at one time. A retired Federal employee, Al is presenting his own views today and testifying on his personal experience as an outpatient at the Washington VA Medical Center. It is also his first appearance before this subcommittee, and we certainly welcome his comments.

Steve, of course, is the VA's Inspector General. He is accompanied this morning by Michael Sullivan, Assistant Inspector General, Office of Audit; and Dr. Alastair Connell, Assistant Inspector General, Office of Health Care Inspections. We appreciate your recent report on the VA's outpatient care delivery.

Without objection, every one of your statements will be made part of the record in its entirety. We invite you to summarize from those statements and we will start with Dr. Klotz.

STATEMENTS OF KENNETH E. KLOTZ, JR., M.D., ASSOCIATE CHIEF OF STAFF FOR AMBULATORY CARE AND ASSISTANT CHIEF OF STAFF, RICHARD L. ROUDEBUSH VA MEDICAL CENTER, INDIANAPOLIS, INDIANA; A.A. GAVAZZI, McLEAN, VIRGINIA; AND STEPHEN A. TRODDEN, INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY MICHAEL G. SULLIVAN, ASSISTANT INSPECTOR GENERAL, OFFICE OF AUDIT AND ALASTAIR M. CONNELL, M.D., ASSISTANT INSPECTOR GENERAL, OFFICE OF HEALTHCARE INSPECTIONS

STATEMENT OF KENNETH E. KLOTZ, JR., M.D.

Dr. KLOTZ. Thank you, Mr. Chairman.

I appreciate this opportunity to appear before this subcommittee to present my personal views on the issue of timeliness of outpatient care services in VHA.

I will provide recommendations in seven major areas, and all of these recommendations we have begun working on in Indianapolis through a primary care/managed care task force that we implemented locally in June of this year.

My first recommendation centers around implementing a health care delivery system centered around a primary care model using

managed care principles. This model can have a positive impact on improving timeliness of outpatient care by several means.

First, as stated by others, specialty clinic waiting times can significantly improve as patients' care is transferred from specialty clinics to primary care clinics.

Secondly, through continuity of care, the majority of outpatient visits for each patient is with their primary care provider, so patient waiting times are significantly less as patients are seen by providers who are already familiar with their care, thus less time is needed to be spent in reviewing the medical record and reviewing the patient's past medical history.

Through the gatekeeper role the primary care provider provides, there is more appropriate referral to specialty clinics and for specialized diagnostic tests which can improve waiting times for these services.

Generalists can also become proficient in performing certain office procedures that are historically usually done by specialists, things like office ENT procedures, et cetera. This can therefore decrease the need for referral to specialty clinics and decrease specialty waiting times and further this concept of one-stop shopping with a primary care provider.

My second recommendation deals with taking appropriate action to assure the level of resources devoted to outpatient care matches the demand for outpatient services. We need to determine outpatient FTE levels and clinic space required to provide timely outpatient care and to expand primary care in light of current demand and anticipated demand for these services.

Expansion of primary care services with its resulting positive impact on outpatient timeliness of care will require implementation of effective strategies to recruit and retain both generalist physicians and midlevel providers.

My third recommendation deals with providing relevant data. We need computer informatics capabilities, and they must be developed to provide relevant data pertaining to outpatient waiting times, but also encompassing the entire outpatient experience from the time the patient drives into the parking lot until the time they leave, and the waits associated with pharmacy, radiology, and the lab.

We need to institute monitors using these data to determine facility performance compared to agreed upon standards developed using both VA and also private sector models with subsequent corrective action to achieve continuous improvement.

My fourth recommendation deals with implementing innovative systems interventions to improve timeliness of service, and you have heard some of them already: Increased use of telephone triage, the use of evening and Saturday clinics, implementing an improved DHCP scheduling package for appointments so that appropriate blocks of time could be scheduled for patients based on the type of appointment and new visit and extended visit or short-term follow-up visit, and implementing VA community-based clinics so care can be rendered closer to the patient's home.

My fifth recommendation deals with improving medical record systems. We need to consider increased use of a separate outpatient medical record that is integrating the most relevant, up-to-date information in a single volume of the chart. We implemented

such a system in Indianapolis in June of this year, and it has already been shown to have improved provider efficiency and perhaps decreased waiting time, but we don't have data on that yet.

We also need to implement an automated, computerized medical record system such as the Regenstrief Computerized Medical Record System. This system is a patient-centered integrated database containing information on diagnostic test results, preventive health interventions, and, most importantly, a diagnostic problem list.

When you use this system, you can have computer-generated reminders that can improve compliance with standards of care and also decrease the time required for physicians and other providers to review the chart to decide when needed preventive health care interventions are needed.

Sixth, develop a patient-centered, customer-focused paradigm. This is of critical importance to assure high quality service is provided to the patient, to obtain needed improvements in timeliness of services, and for the VA to successfully compete with private sector providers in a future market.

Lastly, we need to create incentives. These incentives can help assure that pertinent patient outcome improvements are achieved, like improved outpatient waiting times. These incentives will need to occur at the national level, the facility level, and the level of each individual employee.

In conclusion, there have been problems identified in outpatient timeliness. The Central Office, the RMEC's, and NAVAPAM already have significant and ongoing educational efforts in this area, and I look forward to working with others as we move ahead to aggressively address this issue.

Thank you.

[The prepared statement of Dr. Klotz appears at p. 99.]

Mr. EVANS. Thank you, doctor.

Mr. Gavazzi.

STATEMENT OF A.A. GAVAZZI

Mr. GAVAZZI. Thank you, Mr. Chairman. I am pleased to be here, especially when the Chairman comes from Illinois where I met my wife many years ago—still married.

As an employee of the VA for some 40-odd years, these are strictly my views and based upon my personal experiences, and the important thing that bothers me is the fact that we forget that the patient, the veteran patient, is the most important person. That starts from the director on down to the people in medical administration and down the line. Without the patient, there would be no need for a health care facility like a veterans hospital or clinic.

I have noticed lately that many employees are more interested in pay, benefits, furniture, and computers in their offices than they are in taking care of the patient, the veteran. The comment has been made, putting the veteran first. It sounds good, but all one has to do is go to the canteen or cafeteria at 9 o'clock and between 11:00 and 1:30 and again at 3 o'clock, and you find out that the most important thing is the breaks and the lunch, not the veteran patient. This usually comes first, and that bothers me.

I will give you my own personal experience. I had an appointment at 10:50 at a VA clinic on September 29. I arrived at 10 o'clock. The 24-seat clinic was overcrowded, two wheelchairs were against the wall, nine people standing against the window. I checked in at the reception desk and was told it would be a two-hour wait.

I observed during the next hour and a half that some 12 veterans walked out and had their appointments changed. After a two-hour wait, I was told I would not be seen until early afternoon. I, too, had myself rescheduled to 8:30, October 1.

On my way out of the clinic, I talked to seven veterans who told me that they were very upset and couldn't understand the problem. As I started to leave the clinic area, I noticed several other specialty clinics just as crowded with unhappy veterans.

I reported for my October 1st appointment, arriving there at 8 o'clock, and was seen at 10:15. Supposedly the physician had car trouble. I might add that the physicians were most courteous and thorough once they saw the patient, as was the scheduling staff.

I also found it to be a fact that when the supervisory personnel walk around and observe what is going on, things are done and done quickly and the veteran is taken care of quickly.

Veterans, in my view, are satisfied with the care they get once they get it. Some who are not satisfied write to you as congressmen, and they try to see the top man, and one veteran told me you never get beyond the secretary.

The VA hospital I visited had a computerized system which is very effective, but it does not produce physicians or nurses to take care of the appointment and the patient.

Staff are human. They take days off and get delayed and unexpected emergencies, and usually there is no backup. This is where the chief of the clinic should get involved and do something about it. Where he or she are there at the clinic, the clinic runs smoothly and the veteran patient is taken care of.

When I was working as the director of the VA Medical Center, I made rounds daily, twice a day, in the morning and in the afternoon, saw the patients, saw the staff, and it worked very well. It was very effective, in my view.

Veteran patients as well as patients in the private medical centers or clinics will keep their appointments if they know they will be taken care of. In my view, veteran patient care will improve nationally if the director, chief of staff, and service chiefs get out of their office and see what the heck is going on in their facility. They should see not only the patient but the staff.

There are two other issues I would like to comment on if I may. One is eligibility, and the other has to do with copayments. Eligibility is a disaster. Besides being time consuming and demeaning to the veteran—demeaning, I want to say that again—it is also costly in terms of time to fill out the application and answer all the questions.

Why not have a blanket eligibility for all veterans in World War I and World War II, as they did to the Spanish American War veterans? It worked very well and cut down on a lot of paperwork. I was working then, and I saw it in action.

I recommend a blanket eligibility, if possible, regardless of service connection. Most World War II veterans are eligible for Medicare, a tax-supported health care system which most use.

Copayment is the other problem. It keeps veterans away from the VA hospital. Why should a veteran who lives in Fredericksburg, Virginia, or Winchester, Virginia, or Hagerstown, or Frederick, Maryland, go to the VA hospital in Baltimore, or Martinsburg or Washington or Richmond, when there is a hospital nearby and they have Medicare and Blue Cross and Blue Shield?

I am pleased to have made my comments, and I thank you, Mr. Chairman.

Mr. EVANS. Thank you, Mr. Gavazzi.

Mr. Trodden.

STATEMENT OF STEPHEN A. TRODDEN

Mr. TRODDEN. Thank you, Mr. Chairman. It is a pleasure to be with you once again on an important subject.

In fiscal year 1992, the Veterans Health Administration had 17 million scheduled outpatient visits at its various medical centers and clinics systemwide. Obviously, in a job of that scope waiting times are a very, very important issue, and, as been said many times already this morning, in a competitive environment it gets even more critical.

My Office of Audit, which is headed by the gentleman to my far left, Mike Sullivan, evaluated waiting times experienced by veterans for scheduled outpatient visits at these clinics. His final report was issued in September of this year.

To my immediate left is Dr. Alastair Connell, who brings to the table some individual episodes of care that his office has inspected in the recent past. He also brings to the table substantial academic and university medical center experience that might be helpful.

I would like to say a few words, Mr. Chairman, about the scope of our audit. It was limited, and I acknowledge that right up front. The audit concentrated on the lengths of time that veterans waited in outpatient clinics for scheduled appointments.

We did not review the delays in receiving the initial examinations at walk-in clinics nor in scheduling initial appointments at high-demand specialty clinics since that was a heavy focus of the GAO review, and we planned our work to be complementary to the GAO. I think we succeeded in that endeavor. We are taking a look at, once a veteran has an appointment, how long it takes them to get seen by a health care provider.

Further, we did not look at how long it took to complete treatment. We were fairly favorable to the VA in that we measured from the time the appointment was scheduled until the time the first health care provider put hands on the veteran, so to speak, not when the treatment was finished.

And the last thing I need to inject that we did not look at is a very important question. We did not look at the need for treatment given nor the frequency of treatment. And a couple of statistics jumped out at me as I prepared for this hearing: Roughly 24 million outpatient visits per year, a million inpatient episodes, and about two-and-a-half million veterans occasioning that care. So

with some crude arithmetic, we are talking, on the average, a veteran visiting an outpatient clinic almost once a month.

I don't know whether that is excessive or not. I know there is a high need for repeat visits by certain categories of our veterans, but it also suggests to me at least the possibility that VA has not been very efficient in treating the veteran when he does arrive and when he does get seen.

Turning now to the results of our audit, the details have been pretty well summarized by prior speakers. On the good news side, we did find 56 percent of the veterans that we looked at were seen within the 30-minute standard established by the VA.

On the bad news side, we found that 44 percent were not. Also in that category of veterans who were not seen in what the VA holds out to be a timely standard, they waited an average of an hour and 15 minutes; and some of them, 54 veterans out of our sample, waited in excess of two hours.

At the four VAMC's where we did observe the excessive waiting times, we identified five clinic practices that contributed to these excessive times. In 50 of the 67 clinics—actually, it is 50 of 60, there were seven clinics that we visited twice—one or more of the following practices was evident:

Excessive overbooking of appointments—and I need to emphasize, excessive overbooking. We believe some degree of overbooking is permissible and, in fact, warranted to account for no shows, but still we found excessive overbooking.

Block scheduling of appointments still occurs in the VA even though it is prohibited by VA regulations. That is the practice basically where you tell all the veterans to show up at 8:30 in the morning even if you have no realistic expectation of being able to see them until 11 o'clock, 1 o'clock, or 2 o'clock in the afternoon.

Not allowing sufficient treatment time per appointment—booking each veteran on the basis that he or she is going to need 15 minutes when the patient may, in fact, need 45 minutes. A careful review of the conditions under which they are appearing would make it clear that 15 minutes is inadequate.

Not adhering to established appointment schedules. A veteran will show up, and people will be taken before him or her even though they have a later appointment time.

And, lastly, delaying the start of clinics due to an absence of physicians.

In my opinion, the most overarching issue here is the failure of the VA medical centers we visited to examine their waiting times and to look at their clinical profiles and see whether or not these conditions that we observed were, in fact, causing the excessive waiting time in their clinics. We think, had they done this—and some of these things are not overly complex—corrective action could have been taken to address the problem.

In the interests of the committee's time, I will save a detailed recantation of these various causes for the record or for questions and answers.

I need to inject one very important point, though, on the issue of delaying the start of clinics due to the absence of physicians. We did find this to be the case on multiple occasions. I also need to inject, though, that we did observe many VA physicians who were

arriving early for their clinics, worked through lunch, or stayed late, and so I don't want this issue to get skewed that they are all negligent. In fact, we find very many hard working physicians in the VA.

When we talk about a late arriving physician, it may well be the case that he is late arriving through no fault whatsoever of himself. It may be that the clinic was booked for an 8:30 opening and that physician had rounds that were going to last until 9:30. If there had been some decent coordination, it would have been clear that nobody should ever have expected the physician to have been there at 8:30 or 9 o'clock or whatever the case may be.

As the chairman is aware, we made a number of recommendations to the Under Secretary for Health that outpatient times be monitored; that data at each facility be collected; that there be some identification of those clinics that are experiencing excessive waits, a determination of the causes, and corrective actions; that the clinic profiles need to be updated so that they know what their average time is to treat an average patient; and that patient appointments not be scheduled in excess of the levels recommended by clinic profiles unless required by medical necessity.

The under secretary concurred with all of our audit findings and recommendations and has given us what we consider to be an acceptable implementation plan.

I conclude, Mr. Chairman, with a couple of other points. As I said, Dr. Connell and also my Hotline and Special Inquiries Division field voluminous complaints from veterans. We have focused on a number of those complaints individually and have found them to be frequently validated and have found on occasion that there is clinical adverse impact associated with the excessive waiting.

We also have come to a conclusion that a 30-minute waiting time standard may not be appropriate in all situations, and there may be clinics of a certain specialaty that would require different analysis.

Further, there is the question of how much time is reasonable to wait to be seen by the care giver, and then there is the question of what is a reasonable period of time that clinics should be allowing the care giver or care givers to proceed with the service depending on the nature of the service, whether it is a fairly routine repeat examination of a veteran, or whether it is a first time veteran for which medical records may be pretty sparse. So there are two different extremes, and we think the system needs to account for them.

Although not included in the scope of our audit, as I said earlier, the appropriateness of the length of time it takes to complete an episode of treatment is a factor that must be considered in achieving patient satisfaction with VA outpatient care.

Finally, by addressing our audit findings as well as the other points that I just mentioned, I believe that VA can improve its timely delivery of outpatient care and become competitive under the national health care reform.

Thank you, Mr. Chairman. We are available for your questions.

[The prepared statement of Mr. Trodden appears at p. 107.]

Mr. EVANS. Thank you.

Medical record unavailability is one cause of delay in outpatient care. Steve, what written goals has the VA established for availability? How many VA facilities are meeting or failing to meet those goals? And what, if anything, happens when a facility doesn't meet those goals?

Mr. TRODDEN. Let me ask Mr. Sullivan or Dr. Connell to speak to that question, if they can.

Dr. CONNELL. I can't tell you exactly the percentage that is required in VA standards. One of the measures which is being assessed in VHA's QUIC Program is the availability of medical records.

The majority of facilities have a reasonably high level of availability, and I think the good news is that repeated explorations of this show some improvement. It is a serious problem in an outpatient area and can take an inordinate amount of time.

Mr. SULLIVAN. We have not conducted a thorough review of that particular area. We have seen it as a basic cause of some of the problems in VA health care delivery we have noted throughout the years.

Mr. EVANS. Do you know how often medical record availability performance is determined at each facility, and what is the system doing nationwide to improve this availability for clinic visits?

Dr. CONNELL. Well, as I said, sir, one of the questions which is being asked repeatedly of all medical centers through the QUIC Program is just this very question. As experience is generated at Central Office, I believe there are increasing pressures, some of them simply from a review of facilities' experience in relation to the others, to reach the standards.

Mr. EVANS. Doctor, you talked about the use of computers to help improve the availability of records. Should it have the capability of being available to other medical centers when a veteran goes to a different outpatient clinic, or should this be an in-house kind of availability?

Dr. KLOTZ. It could be either. You could have systems to share the data through electronic mail between both facilities, from different facilities, especially within a network of facilities where you were referring patients back and forth.

Mr. EVANS. I have been to a few VA hospitals which have had difficulty maintaining their work force and filing records. Is this going to be a way of dealing with that issue as well? Instead of having people deal with piles of documents to be inserted into the records, will this make it easier and perhaps cheaper for the VA to have records available?

Dr. KLOTZ. I can't comment on the cost. It should make it easier.

One thing behind the outpatient functional record which I mentioned with the written record is that we found sometimes a veteran would have four or five volumes of a chart, and sometimes things would get misfiled, like some of the more recent stuff would be filed in volume four instead of volume five, and they would pull volume five for the clinic and you wouldn't have all the information, and that is why we felt like since most health care is outpatient, it made sense to have a single volume of outpatient with important inpatient data stuck in certain parts of that in designated spots.

Mr. EVANS. You have given us a check list for VA actions needed to improve outpatient care. What do you think the VA realistically could do with your check list in the next year's time? Could it implement many of those goals without much cost cr without much delay?

Dr. KLOTZ. Again, I can't comment on the cost, because I don't have any data on that. I think the work has begun. Certainly, as I said, work has begun at Indianapolis to address these areas. Work has also begun at other facilities as well, and it is being looked at in Central Office, and there are mechanisms to share these things with the field. This has come up in other segments of the presentations. There have been several training programs put on by the regional medical education centers and the CEC's and the Central Office, including a number within the last year and a half, all sharing information on models of primary care and managed care between facilities.

We are also planning a program in NAVAPAM to deliver strategies of efficient primary care/managed care for this spring for ambulatory care physician managers.

So there are several mechanisms to share these models.

Mr. EVANS. According to your testimony, the primary care approach is not only useful for the veteran in giving continuity of care, but it also makes the VA physician more efficient. Can you elaborate a little more on how that makes the doctor more efficient?

Dr. KLOTZ. When you are familiar with the patient, there are incredible time savings because you know what has been going on with them throughout several years time up till the present. So you don't have to waste time going over past medical history or reviewing a lot of old records, you can just kind of take off and run with where the patient is at the moment. So that a lot of time could be saved in that. Also, there is just the fact that patients are more satisfied when they have a primary care provider and they are happy with their care.

Mr. EVANS. You testified about using primary physicians as a gatekeeper to specialty care. Can you describe that process generally?

Dr. KLOTZ. This would be where, for instance, through teaching programs that you have for faculty and for house staff and medical students, you teach them how to effectively, as primary care physicians, take care of problems that a lot of people historically have just knee-jerk referred like a low back pain to a neurosurgeon or low back pain to orthopedics.

It has been shown that general internists can effectively handle most all low back pain. So there is no need to refer to these costly specialists and clog up their clinics.

Also, effective strategies that you don't have to order an MRI scan for every case of low back pain, and thus decrease the referrals for MRI, it decreases cost and improves waiting times for MRI's.

Mr. EVANS. Before I yield to the gentleman from New York, I would like to ask Mr. Gavazzi a question.

During a subcommittee hearing in April, 1991, on VA delivery of benefits and services in the District of Columbia, Mr. Williams, the

director of the VA Medical Center, told this committee the following about waiting times: "The waiting times have been long in some clinics, and we have undertaken an extensive study of the clinics relative to the time that they are scheduled, the availability of staff, timeliness of staff arriving, and whether or not we needed to establish new clinics that would cut down on the waiting times. The physicians that operate the ambulatory care area are evaluating what we have found and will make adjustments. It may mean that we have to add some clinics, it may mean that we will have to extend clinics into the evening so that we can reduce the waiting time."

In your opinion, Mr. Gavazzi, did this extensive study two years ago succeed or fail in reducing waiting times for care at the Washington VA Medical Center?

Mr. GAVAZZI. Not in my view. I have been going out there for the last five years. I am a service-connected veteran, and I go out there for my service-connected disabilities frequently, and I can tell you that it hasn't changed. There are still long waits, and I don't think half of the staff know who Mr. Williams is. He doesn't get around to find out what is going on, and that is the job of the director, to get around and be seen and do things.

That is why I made rounds as I did. I was known, and if someone had a complaint, they made it to me when I was director at that facility, and unfortunately some of our directors think they could operate from their desks. You cannot do that, sir.

Mr. EVANS. Are you going back next February?

Mr. GAVAZZI. Yes, sir, I have an appointment on February 2.

Mr. EVANS. We would appreciate a report from you as to what your experience is in February.

Mr. GAVAZZI. I would be happy to give it to you, sir.

Mr. EVANS. Let me yield to the gentleman from New York.

Mr. QUINN. Thank you, Mr. Chairman.

Gentlemen, thank you for your testimony.

I think it is important, as Mr. Trodden said, that we don't try to skew this report or any report that all of the employees at all the VA centers are late for work and aren't doing a good job, because indeed we have heard testimony in this room about some hard-working staff members.

At the same time, people don't make these stories up. Many of us have been to many hospitals or a dentists' office ourselves and had to wait a reasonable amount of time.

Mr. Gorman testified earlier today that he felt there were some things that could be done immediately that didn't cost a lot of money, and I am encouraged by some of those things. Your comment doctor, to share that information makes awful good sense to me.

The question is, is there anything, in your opinion, Mr. Trodden—we have heard already about extending hours, evening hours, Saturday hours, a telephone system, flextime for some people—that we could do in the short term that wouldn't cost a lot of money that are working somewhere else. How do we get that information out? Is there anything you can suggest, short of another two-year study, that looks at all the problems?

Mr. TRODDEN. I would be glad to jump into that one, Mr. Quinn, and I hate to sound like a broken record because in a number of appearances before this committee I think I have said pretty much the same thing. But I subscribe to your views. I think the ideas are on the table.

I am frustrated as to why it seems to take so long to export them. I have said to the prior Secretary and have said to the current Deputy Secretary that I know there is a lot of talent in the VA. I know the gentleman to my right has probably got a world of experience on how to run an outpatient clinic. I don't know why VA can't take five or ten of their best outpatient directors, lock them in a room, tell them, "Come up with the five concrete things that we are going to do systemwide, ten things, or whatever the bright ideas are," and when they come out of that room, mandate that it happens.

It seems like every time I am up here I say that the rules are pretty good, generally speaking. Like I mentioned in my statement, there is already a rule against block scheduling patients, yet we go out and look at four hospitals, and they are all block scheduling.

It seems to me that the key here is an Under Secretary for Health who locks these people in a room and they come up with their ideas. It is perfectly TQM-ish, it is bottoms up; they decide what they need to do to address the situation, and then he endorses it, and then he makes it happen, and he rewards the people who do it, and the people who don't do it are penalized. I think it is just as simple as that.

Mr. QUINN. So, in your view, there are some things that we have talked about that have been discussed and studied already, and I wouldn't even be as optimistic to say come up with ten. I think if we are going to make these places user friendly for patients, for veterans, that even if we did two or three, in the short term it would show some light at the end of the tunnel, and, who knows, somebody might get the idea that we are out there to help each other.

Mr. TRODDEN. I think the Secretary has clearly given the Department the challenge and the right direction and his thoughts are perfectly well founded.

Frankly, I think the selection of the next Under Secretary is key. He has got to do the kinds of things we have discussed here today, and once he has those good ideas, then he can't worry about popularity contests or peer acceptance, he has got to make them happen.

Mr. QUINN. Thank you.

Thank you, Mr. Chairman.

Mr. EVANS. Thank you.

Doctor, there was an article recently by three VA employees in the American Journal of Medical Quality, and they say, "The glut of specialists is directly related to the current reduction in overall quality of care and is contributing the spiraling health costs that now threaten our entire national economy."

Do you agree or disagree with that statement?

Dr. KLOTZ. Did you say the increased use of specialists and subspecialists itself?

Mr. EVANS. The glut of specialists and subspecialists.

Dr. KLOTZ. I think that primary care is a more effective and more cost-effective way of delivering care and could theoretically decrease costs. So if I understand what you said, I agree with that.

Mr. EVANS. Thank you.

The VFW mentioned that many VA facilities, if not most, only have one examining room for each doctor. Is that true in your case?

Dr. KLOTZ. It depends on the clinic area you look at. We have several clinic areas, several different sized. We have a new building going up now. It will be done in the spring. We found just subjectively—and we haven't rigorously studied this—that it is more efficient to have at least two examining rooms per provider. A lot of that depends on the clinic too and how fast they move, like a dermatology clinic can move pretty quickly, whereas a clinic that is doing a lot of new patient evaluations may take longer with people with chronic medical conditions and multiple medical problems; they may be in the room with the patient longer.

But, nevertheless, we found that when you have at least two examining rooms per provider, it can improve efficiencies and timeliness.

Unfortunately, you don't always have the ability to have enough space to work with to be able to do that, and so that does need to be addressed.

Mr. EVANS. Do you think the efficiencies are close to what the VFW predicted, that if you had two rooms there might be a 30 percent increase, for three rooms per physician there might be a 50 percent increase?

Dr. KLOTZ. I am not sure about the three rooms. I think two rooms, 30 percent, could be right.

Mr. EVANS. I thank this panel very much.

We will have some additional questions for all of you, I believe, and your written responses to those questions will be made a part of the record.

Thank you very much for your participation this morning.

[The questions and answers appear at p. 117.]

Mr. EVANS. The members of our final panel represent the Department of Veterans Affairs. Dr. Elwood Headley is the Acting Under Secretary for Health. He is accompanied by Sandy Garfunkel, Associate Chief Medical Director for Operations, and Kenneth Ruyle, Director of the Medical Administration Service, Veterans Health Administration.

Dr. Headley, your prepared statement will be made part of the record. You are invited to summarize your prepared remarks and please begin when you are ready.

STATEMENT OF ELWOOD J. HEADLEY, M.D., ACTING DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS ACCOMPANIED BY SANFORD M. GARFUNKEL, ASSOCIATE CHIEF MEDICAL DIRECTOR FOR OPERATIONS AND W. KENNETH RUYLE, DIRECTOR, MEDICAL ADMINISTRATION SERVICE, VETERANS' HEALTH ADMINISTRATION

Dr. HEADLEY. Thank you, Mr. Chairman. I appreciate the opportunity to discuss VA's outpatient treatment programs today.

VA provides a wide range of services to veterans through its ambulatory care programs. Outpatient services are provided at 170

medical center outpatient clinics, 53 satellite clinics, 44 community-based clinics, 81 outreach clinics, seven independent clinics, and six mobile clinics. This is a total of 361 outpatient care activities. VA also provides outpatient services through its home care, homeless, and counseling programs.

Where VA facilities are not accessible for veterans with a high priority claim to service, VA contracts for care in the local community. In fiscal year 1993, veterans made 24.1 million outpatient visits, and we anticipate 24.6 million in fiscal year 1994.

Mr. Chairman, the General Accounting Office and the VA Inspector General have recently recommended improvements to VA's outpatient programs. VHA has concurred generally with these recommendations and is taking corrective actions.

While these audits found deficiencies in management of some outpatient programs, they also identified innovative approaches that several VA medical centers are taking to improve service to veterans.

Mr. Chairman, our long-term approach to improving our outpatient programs will be to implement the President's health care reform program through a managed care/primary care strategy within VA. Currently, we are making progress toward implementing primary care concepts. In the immediate future, the under secretary will issue guidance to all VA facilities urging progress toward implementing primary care and improving timeliness of outpatient services. This directive has already been signed and is in the process of going out.

We are issuing directives which will clarify requirements to monitor the timeliness of services provided in each VA scheduled clinic, and this requires quarterly review and analysis of waiting times in outpatient clinics.

It must be recognized that medicine is difficult to schedule. Physicians feel that it is preferable to spend whatever time is necessary with a patient even if it means keeping others waiting.

There is difficulty in defining an ideal time slot that can conveniently accommodate patients. An elderly veteran with multi-organ disease and no previous medical records can require an hour of a care giver's time even though clinics may routinely allow only 15 or 20 minutes per slot because of the time required for the average patient in that clinic.

Emergencies are unpredictable and take priority over scheduled appointments. Also, it is impossible to always predict walk-in demand and have staff available. Some delays are truly unavoidable.

VA has some particular problems which compound the situation. Demand for VA care generally exceeds our ability to supply it, and many veterans have no alternative source of care. VA clinics stretch their resources to care for as many patients as possible, but are not able to care for all veterans who apply for services.

We also face the daunting task of developing and delivering primary care services while continuing to provide tertiary care services because it is necessary to provide tertiary care services to patients enrolled in primary care when further needs are discovered through their primary care physicians.

Nevertheless, we believe that improvements are possible and efforts are under way to improve our outpatient programs. VHA is

developing a plan to implement managed care that places emphasis on primary care. A managed care/primary care strategy will be crucial to VA's success after national health care reform. VA care will have to be comprehensive, coordinated, cost-effective, and delivered in a timely manner if we are to succeed in national health care reform. Full implementation of this strategy will require implementation of the President's plan for health care reform.

We are requesting medical centers to increase efforts to implement primary care as a means of improving timeliness of outpatient services.

VA hospitals have already developed outpatient managed care systems in a variety of settings. The GAO recommendations to establish telephone assistant networks, to provide patient scheduled appointments, the transfer of specialty patients to primary care, and to manage the care of patients in all settings have been implemented by many VA medical centers.

Other initiatives under way to improve our ability to provide outpatient services include scanning the country for the best solutions nationally and replicating them throughout the system by means of presenting them in national training programs that will reach every VA medical center. Dr. Klotz and many of his colleagues who are experts in the delivery of outpatient care have participated in the development and the presentation of these programs. The first was in Tampa. These will be continued throughout the year.

Mobile labs are being established to expedite some of the basic tests; Pharmacy Without Walls has been developed to reduce waiting times; and the Pharmacy Services are pilot testing a highly automated responsive system to provide outpatient medications.

Mr. Chairman, our future depends on VA's ability to provide high-quality and responsive outpatient services. The recent GAO and IG audits found problems in our program that require immediate attention. Passage of the President's health care reform proposal and implementation of managed care and primary care strategies in VA is needed to allow VA to achieve maximum use and benefits from its outpatient programs.

Thank you.

[The prepared statement of Dr. Headley appears at p. 114.]

Mr. EVANS. Thank you, doctor.

Secretary Brown has reported space deficiencies, staffing shortages, and budgetary issues that he says contribute significantly to certain medical centers' abilities to provide efficient services. Do you know how many veterans facilities are having trouble providing efficient services and which ones they are?

Dr. HEADLEY. I can't give you a definite number, but my guess would be that it is at least three-quarters of our facilities in terms of outpatient facilities.

As you know, our system was built and devised at a time when tertiary care and inpatient care were the primary modes of treatment. As a result of this, adequate attention was not paid to the development of outpatient care facilities.

We have been attempting to retrofit to deal with this; attempting to use spaces in an innovative way, and in many facilities indeed this has been possible. But in many of our other facilities there still exist space and staffing shortages.

I will ask Mr. Garfunkel if he could comment on perhaps a better estimate of the numbers of facilities that would have difficulties in these areas.

Mr. GARFUNKEL. Thank you.

I also do not know the exact number, but I would think Dr. Headley's estimate of about three-quarters of our facilities is probably a good estimate. We do have some figures from various plans that show the number of facilities that actually have deficits in those areas.

Mr. EVANS. Are you talking about space only though? The other issues that the Secretary raises are staffing and other budgetary issues.

Mr. GARFUNKEL. I was referring to space only. I think the staffing and budgetary issues probably exist in virtually all of our facilities.

Mr. EVANS. How much do you think, just on the issue of having adequate space, would it cost to totally eliminate this deficiency?

Mr. GARFUNKEL. It would just be a guess, but I would guess in the area of a couple of billion dollars. Between one and two billion dollars.

Mr. EVANS. As we go into national health care reform, are we going to have the upgrading of those facilities to that amount?

Mr. GARFUNKEL. We have discussed various plans in Central Office for moving towards national health care and various estimates of construction needs, and it certainly includes updating our outpatient facilities to meet those needs.

Mr. EVANS. Concerning budgetary issues that the Secretary alluded to, according to CRS, since 1982 Congress has appropriated $7 billion more than the Presidents under those respective administrations requested for the VA. Has the Veterans Administration failed to request the resources needed for VA ambulatory care, or have sufficient resources been requested, but poorly used?

Dr. HEADLEY. I believe that much of the $7 billion that has come to VA has been used to overcome deficits in previous years throughout the system in ambulatory care areas as well as in tertiary care or inpatient areas.

Mr. EVANS. That is $7 billion more than what the presidents of different administrations requested. So is that a failure of Congress, or is that a failure of the administrations in those different years to request the money?

Dr. HEADLEY. I don't think it is a failure of either. I think it was a good faith attempt to overcome a backlog of need from many, many years in the past of underfunding, and I think that great strides have been made in improving conditions in VA medical centers, but I think that we still have a long way to go.

In terms of staffing—you had asked about staffing, and I concentrated mostly on space—the Secretary's comment about staffing, one of the things that concerns me frequently when we discuss the development of primary care initiatives in VA and the fact that VA must have a primary care focus and develop full primary care, it is almost an assumption in these conversations that tertiary care needs will somehow be greatly reduced, and I don't know, indeed, that that is a fact.

When one provides primary care in a system of integrated health care, there are tertiary care and inpatient care needs that are recognized and must be dealt with, and so while I do feel that it is possible that some reallocation of staffing from inpatient care to primary care is certainly possible through various efficiencies, I think that we must keep in mind that dismantling our very good tertiary care system in order to provide primary care would leave us without the capability of delivering a full range of services to the patients for whom we are committed to deliver care.

Mr. EVANS. Understanding that, and also understanding the need to come up with at least $2 billion just for space deficiencies that currently exist, I want to note that today's *Washington Post* carries an article about what the OMB is proposing in terms of the new health care plan. It reports, "Leon Panetta announced a number of changes in how the Federal Government would come up with the money to pay for the plan between 1995 and the year 2000," and the article also says $40 billion from savings in Federal health programs such as the Department of Defense, Veterans Affairs, and Federal employees.

Now, how can we obtain those dollars for savings to finance the whole program—it is just one of the major components—one of several major components—and still upgrade the VA's outpatient care clinics and maintain the tertiary care?

Dr. HEADLEY. I don't know.

Mr. EVANS. You don't know.

Well, the Secretary has a three-year plan, I understand, to implement managed care over the next three years. That is going to require at the outset some additional resources to implement. Is that correct?

Dr. HEADLEY. It is very likely that it will.

The resource implications of implementing managed care have not been fully developed. We have been proceeding with attempting to implement the things that we can implement without additional resources while working on projections for additional resources that may be required.

We feel that we can implement such things as telephone assistance networks, primary care clinics, limited primary care clinics, beginnings of primary care clinics, without additional resources. But as we proceed to enrolling every patient in primary care, it is very likely that we would need additional resources.

Mr. EVANS. Have you been appraised of this $40 billion item that OMB has proposed?

Dr. HEADLEY. No.

Mr. EVANS. You have no idea of what it is?

Dr. HEADLEY. No.

Mr. EVANS. If the administration is talking also about military cutbacks in the military medical system, is the VA preparing for the downsizing of the military, what impact numerous new veterans coming out of the Armed Forces might have on its planning not only just for outpatient care but for the Veterans Administration in the new area of medical reform?

Dr. HEADLEY. We have not gotten into this as yet. There were some discussions during the White House task force working groups in which VA participated with DOD and Indian Health

Service on some of the implications to other services if certain scenarios were played out in other services, but in terms of actual planning for these eventualities, I am not aware that this has gone on at this point in time.

Mr. EVANS. Can you submit to us your views of the impact of these $40 billion cuts and where they are going to come from? We would like to include this in the record.

Dr. HEADLEY. Yes.

(The information was not provided for the record.)

Mr. EVANS. Is the VA's managed care/primary care strategy completely detailed in writing, and what is its status today? Is that strategy the directive you talked about?

Dr. HEADLEY. The directive that is going out is a directive directing the implementation of primary care clinics in hospitals.

Mr. EVANS. Can you provide that for the record?

Dr. HEADLEY. Certainly, yes.

(See p. 133.)

Mr. EVANS. Let me yield to minority counsel for questions she may have.

Ms. DONOHUE. Thank you, Mr. Chairman.

Dr. Headley, there is no distinction made when it comes to outpatient care for service-connected and nonservice-connected veterans, they are all accepted on a first come, first served basis. Should the service-connected disabled veteran receive priority consideration for treatment?

Dr. HEADLEY. Yes. I am going to refer that—I have difficulty with your statement because I don't believe it is correct, and I would like to refer that to Ken Ruyle who might have some of the rules.

Mr. RUYLE. Let me make sure I understand what you are saying. When you say there is no distinction, are you talking about in scheduling the appointment or in eligibility for the treatment, because there is a difference in the eligibility.

Ms. DONOHUE. Nonurgent, unscheduled.

Mr. RUYLE. Nonurgent, unscheduled appointments. No. Once they are eligible for the treatment, we schedule the appointment based upon their medical necessity first, and we don't give a priority there for the service-connected veteran.

Ms. DONOHUE. Should you?

Mr. RUYLE. I am not sure. I think the medical necessity should probably take precedence once we accept a veteran for treatment, that we should follow up based on the medical necessity, in my opinion. That is not to say that we should not be treating service-connected veterans in any way, so don't misunderstand that. I am presuming both are going to receive the medical treatment they need once we accept them into our system.

That is one of the problems we have, of course, with the overbooking and some of the extended waits. Of course, the demand is simply greater than what we are able to provide in some instances.

Ms. DONOHUE. Does VA have in place any incentive system to reward staff for achievements based on productivity and timeliness of services rendered?

Mr. GARFUNKEL. Yes, we do. We have a system of rewards where people have performance standards and are rewarded at the end of

the performance period based on their performance, which includes productivity standards as well as special contribution awards that individuals receive for particular efforts in various areas including decrease in waiting times and increases in productivity.

Ms. DONOHUE. The Inspector General observed that 22 of the 67 clinics reviewed were delayed by an average 37 minutes because of the late arrival of physicians. Additionally, three physicians staffing at an orthopedic clinic were late returning from lunch by an average of 50 minutes. Please tell us the reason for such delays and what actions have been taken to discourage this behavior.

Dr. HEADLEY. I think that is a regrettable finding. I think, as Dr. Klotz pointed out and Mr. Gavazzi mentioned, in well-run ambulatory care activities, outpatient care activities, there is ongoing oversight by the clinical leadership, and conditions such as this are spotted and are remedied on the spot. I think that that is unacceptable when it occurs capriciously.

We have to be very careful before passing judgment, however, that we know all of the conditions that might be existing. The surgeons may have been in surgery through the lunch hour and may have taken ten minutes to run to the cafeteria and grab a sandwich which they ate in the elevator on their way to clinic. This happens not infrequently.

Medicine is often difficult to schedule as emergencies occur; things happen in surgery that are unanticipated. It happens in private physicians' offices as well. It happens in university hospitals, and it happens in HMO's.

I think, however, that the key to working with this is for local administration to constantly be aware of activities in their clinics, to review their clinic profiles, and to spot issues such as this and deal with them in an effective manner.

Ms. DONOHUE. Thank you.

Thank you, Mr. Chairman.

Mr. EVANS. Regarding VA's plan for managed care, the Secretary has reported that the VA will implement its approved strategic planning goal of managed care over the next three years. For each of the next three years, what does the VA plan to accomplish with respect to implementing its approved strategic planning goal of managed care?

Dr. HEADLEY. The managed care plan, as it currently exists, has developed all of the areas that need attention.

A managed care task force functioned over about the last seven or eight months with wide input from the field. Dr. Klotz, I believe, was a member of that managed care task force as well as several other people involved in the delivery of ambulatory care; and issues of information needs, care delivery needs, models of care, and so forth were developed, and specific recommendations as well as offices to implement these recommendations were developed.

The Secretary has recently charged a program office with taking the recommendations developed by the managed care task force and from other sources and implementing them over the next three years, essentially developing implementation plans.

The actual time lines for implementation have not as yet been developed. One of the goals of that office, however, is to proceed with things that can be easily implemented in an expeditious fash-

ion such as the primary care directive which, as I said, is in the process of going out.

Mr. EVANS. In what form does the plan currently exist?

Dr. HEADLEY. It exists as recommendations.

Mr. EVANS. Can you submit those recommendations?

Dr. HEADLEY. Yes.

(See p. 133.)

Mr. EVANS. Which office has responsibility for drawing up those recommendations?

Dr. HEADLEY. It was a managed care task force which was charged by the Under Secretary for Health.

Mr. EVANS. And which office will implement them?

Dr. HEADLEY. All of the offices in VHA.

There were wide-ranging recommendations having to do with information management, with models of care delivery, all aspects of care.

Mr. EVANS. Did you indicate one office was charged by the Secretary to implement it?

Dr. HEADLEY. There is a new program office for responding to national health care reform which has just recently been developed by the Secretary, charged by the Secretary.

Mr. EVANS. Who is in charge of that office?

Dr. HEADLEY. I am. It functions out of the Under Secretary for Health's Office.

Mr. EVANS. We heard earlier about disincentives. Some clinics had developed telephone assistance networks, but the people who were assisted by telephone weren't being included basically in the so-called body counts, the statistics that are kept by the VA. Is that true?

Dr. HEADLEY. It is historically. RPM has developed a mechanism—and I may defer to Mr. Garfunkel—to include this information in work load.

Mr. GARFUNKEL. As you probably know, this year we have instituted for the first time a new system of budgeting, RPM, that accounts for the whole patient rather than for some inpatient episode of care.

So I would say the incentives for this year were neutral as far as telephone calls, because you did receive reimbursement for your costs. Presumably the telephone program would lower costs, you would receive a little lower reimbursement, but it would still be for your cost.

Mr. EVANS. Incentives are neutral for——

Mr. GARFUNKEL. No. I need to finish.

Mr. EVANS. Please proceed.

Mr. GARFUNKEL. As of now, we are in the first development of RPM.

However, one of the real problems we have had with RPM in how we implemented it for 1994 was this lack of incentives, and we have had groups working—from the very day we agreed on the RPM model for 1994, we have had groups working on incentives. One of the primary incentives we have asked them to work on is exactly this issue, ways that we can reduce the costs of outpatient care, such as the telephone issue, and see that medical centers are then rewarded for lowering those costs.

So I am sure that when we distribute our dollars for the 1995 budget under RPM this coming spring or this coming summer, it will include those incentives in the distribution of dollars.

Mr. EVANS. How many of the VA's more than 260 medical center satellite community-based clinics have a telephone triage program today? And does the Department believe that enough have those kinds of programs today?

Mr. GARFUNKEL. I would trust the number used before of 20 to 25 is probably accurate. The answer is no, we don't believe we have enough, and we certainly need to encourage it and provide the incentives for medical centers to do that.

Dr. HEADLEY. If I may just add a comment, last year I suspect there were five, and we are seeing them come on line daily. As people get the message that this is an effective way to reduce overcrowding and to deliver better patient care and improve waiting times, they are developing them with great rapidity.

We are also educating people about them through our national training program on the delivery of primary care.

Mr. EVANS. You talk about incentives and encouraging and educating. What about directing medical centers to have these kinds of programs? Why don't we just say, "You have to do this, and here's how you do it"?

Dr. HEADLEY. That is a good idea.

Mr. EVANS. I am sorry?

Dr. HEADLEY. That is a good idea.

Mr. EVANS. Do you think we can do that next year?

Dr. HEADLEY. Yes.

Mr. EVANS. Your statement, Dr. Headley, notes innovative approaches for improving services to veterans are used by few VA facilities. Does the Department believe use of these or other innovative approaches by other VA facilities must be preceded by passage of the President's health care reform proposal?

Dr. HEADLEY. No, sir, we do not. We believe that we should be implementing these innovative programs across the system.

What we have done over the past two years is go out to all of our VA medical centers across the country and look at what innovative programs in primary care delivery existed. We gathered these together in the Office of Ambulatory Care, and we have selected examples of them that meet the needs of the variety of our hospitals across the system. We have large, urban, tertiary care hospitals, we have small, rural, nonaffiliated hospitals, and they have somewhat differing needs in terms of the structure of primary care delivery.

In our educational programs, we present some ten of the best models that we have across our system, and we are encouraging people to develop these programs at the present time in their facilities, and indeed, as a result of the first program, we had a followup survey, and some 20 to 25 percent of the hospitals who had attended the educational intervention within three months had developed and initiated primary care in their medical centers.

In addition, we recently completed a survey nationally of primary care activities in our VA medical centers, and over 60 percent of our medical centers at this point in time have in place primary

care activities that they are working on and expanding. We are in the process of getting the rest of the facilities to do the same.

Mr. EVANS. Sandy is very familiar with the next issue that I am going to raise and probably surprised why it took me so long to do so.

The VA is currently reviewing whether to establish a permanent outpatient facility in Quincy, Illinois. This facility would be established for very small cost on the grounds of the State Veterans' Home located in Quincy. Establishing outpatient clinics at existing State or Federal facilities appears to be a low-cost way of expanding needed services to veterans. Does the VA regularly consider using existing underutilized facilities for those purposes?

Mr. GARFUNKEL. We have discussed that a great deal. We do regularly consider it. We realize that in the coming atmosphere of national health care, where perhaps we will be looking to establish a lot of these community clinics, that this is a very, very cost-effective way of doing it by using existing facilities; as well as with the downsizing of the military, we have discussed the possibility of using military facilities.

So yes, we do, and we agree it is a very cost-effective way of doing it.

Mr. EVANS. And we are hoping that Quincy, Illinois, will be one of these model programs.

Mr. GARFUNKEL. I think it will be, Mr. Congressman. We are negotiating with the region on the cost, and I think we will be fine with it.

Mr. EVANS. Thank you very much.

Let me yield to minority counsel in case she has any other questions.

Ms. DONOHUE. I have no more questions, thank you, Mr. Chairman.

Mr. EVANS. I want to thank this panel, and I want to thank all witnesses for testifying and giving us their contributions today.

Whether national health care reform is achieved sooner or later, I think it is clear that reform in the VA outpatient care is needed now. There is no compelling reason to delay even one more day in truly putting the veteran first, as Jesse Brown has stated. Veterans should receive only the best possible health care, but today the care given to some veterans by the VA is less than first class. These will continue to be issues of great importance to this committee.

Thank you all for joining us, and we will conclude the hearing at this point.

[Whereupon, at 11:10, am, the subcommittee was adjourned.]

APPENDIX

STATEMENT OF THE HONORABLE TOM RIDGE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS COMMITTEE ON VETERANS' AFFAIRS

HEARING ON TIMELINESS OF VA OUTPATIENT CARE

October 27, 1993

Mr. Chairman, I would like to commend you for not only scheduling today's hearing, but also your foresight two years ago in requesting that GAO examine VA's ambulatory care system to determine how long veteran's wait for care, identify factors causing service delays, and recommend ways to shorten veterans' waiting times.

I believe that it is very appropriate that we hold this hearing the same day that the President is presenting his National Health Care Plan to Congress. Ensuring timely outpatient health care for our nations veterans has always been a top priority for this Committee. However, given that President Clinton's plan proposes that VA competes with private sector hospitals, the VA medical centers have absolutely no choice, except to improve their outpatient care services.

If the VA continues to make patients wait anywhere from an hour to three hours for care, then they will not be able to compete with private sector providers. This is especially true in light of the fact that many of these veterans are waiting only to have routine questions answered and prescriptions refilled -- acts that can easily be accomplished through an efficient telephone assistance network.

It is time that the VA hospitals begin to treat veterans as customers and structure an outpatient system that provides them with quality and timely care. I am pleased to know that the Veterans' Health Administration has concurred generally with recommendations by both GAO and the VA Inspector General and have agreed to implement them.

Mr. Chairman, I welcome our distinguished witnesses and look forward to hearing their testimony.

Statement of the Honorable Jack Quinn
October 27, 1993
Subcommittee on Oversight and Investigations

Mr. Chairman, I am pleased to be here this morning to look at an issue that is becoming more and more important to this Subcommittee, the Full Committee and the entire VA system - the timely delivery of VA outpatient care.

If the VA is to remain competitive as national health care reform is implemented, veterans must see outpatient care as an attractive and dependable option.

I have to say I was distressed by some of the findings laid out in the recent GAO report; as reported by the Inspector General; and also as provided by the Veterans of Foreign Wars' National Veterans Service staff regarding the timeliness of outpatient care.

The reports of delays, backlogs, overbooking, cancellations and insufficient treatment time are disturbing.

As you are aware, Mr. Chairman, it has been reported that an average of 3.7 patients per day walk out of the Baltimore VA Medical Center without receiving medical treatment or seeing a physician. That is disgraceful. Similar incidents have been reported at other VAMCs.

The fact that a veteran at the Audie Murphy VA Medical Center traveled 250 miles to the center for a 9:00am appointment scheduled for the following day and then found that his appointment was cancelled is inexcusable.

While I am pleased to report that the VA Medical Center in my district back in Buffalo seems to be doing better than most, Mr. Chairman - I have heard from disillusioned constituents back home.

I would like to share with you a letter to the editor that appeared in the Metro Community News. Mr. Charles O. Powley of Niagara Falls writes that he is a 100% service connected veteran who lost one leg and has steel plates in his other. He has had difficulty obtaining timely appointments for care for his knee.

Mr. Powley wonders, "When, if ever, is our government going to carry out the promise they made us, to care for the disabled and disadvantaged?" He further states, "I'll celebrate the 50th Anniversary of World War II, for I sure as hell died there on Thanksgiving Day of 1943."

Mr. Powley should not have to think this way.

Unreasonable waiting times for initial appointments and follow-up clinics impede care; lower morale and could worsen the patient health situation. Lengthy patient processing time certainly effects the efficiency of operations. These issues are very, very serious.

As we examine the role of the VA Medical System in National Health Care Reform, it is imperative that we look at the strengths of our system and improve upon them. We must also take a long hard look at what we are not doing particularly well.

In order for VA to compete, it must provide the best possible care in the best possible manner. In a world of health alliances, timeliness will more likely than not be the deciding factor in whether a veteran chooses VA or not.

Mr. Chairman, I am looking forward to hearing the testimony on the delivery of outpatient services and learning what we can do in Congress to facilitate recommendations for improvement.

Metro Comm News
Sep 12 '93

WWII vet decries VA hospital

Dear Editor,

Veterans Hospital and World War II, a great combination because they are, and were, a mess.

WWII destroyed a great many of the young of the world. The Veterans Hospital ignores, or says they can't handle, their heavy case load. They don't have the doctors to operate, or the nurses to care for you after the operation.

Most of the clinics are a mess and you can wait for hours to be seen and then you are sent home no better off than you were before your clinic visit, in most cases.

I speak from experience as I am a WWII, 100 percent service connected ex-Marine who lost one leg and has had a steel knee replaced four times in the other leg because of pain and malfunction of various parts.

To get into the Buffalo VA Hospital, you have to wait for months before they can get around to servicing you, like a broken down car in a garage. I was supposed to have an appointment on the 23rd of August, but because they do not have a doctor to see me I have to wait until Nov. 8. I need new knee X-rays, and even though they do find what the knee trouble is, I will probably have to wait several more months to have any repair work done.

When, if ever, is our government going to carry out the promise they made us, to care for the disabled and the disadvantaged?

Some members of the government want to admit non-veterans to VA hospitals. How can they care for these people when they can't even care for the patients the hospital was planned for?

Yes! I'll celebrate the 50th anniversary of World War II, for I sure as hell died there on Thanksgiving Day of 1943.

Charles O. Powley, Niagara Falls

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

For Release
on Delivery
Expected at
8:30 a.m., EDT
Wednesday,
October 27, 1993

VETERANS AFFAIRS

Service Delays at VA Outpatient Facilities

Statement of
David P. Baine, Director,
Federal Health Care Delivery Issues,
Human Resources Division

GAO/T-HRD-94-5

SUMMARY

In mid-October 1993, GAO reported that veterans experienced lengthy delays when they receive medical care in the more than 200 outpatient facilities operated by the Department of Veterans Affairs (VA). Veterans frequently waited 1 to 3 hours before having their nonurgent conditions examined by a physician in VA's emergency/screening clinics--the entry point for veterans initially seeking care. In addition, veterans waited an average of 8 to 9 weeks to obtain appointments in specialty clinics, such as those for cardiology or orthopedic clinics, which treat more complex medical conditions.

Inefficient operating practices are major contributors to veterans' service delays. For example, VA's emergency/screening clinics generally require veterans with nonurgent conditions to walk in to obtain care rather than call in advance to schedule visits to general medicine clinics. Because these veterans are treated on a first-come, first-served basis, they tend to arrive in the early morning hours and overwhelm clinic staff. Such uncontrolled workloads result in needless waits, dissatisfied veterans, and stressful working conditions for VA staff.

In his recent proposal to reform the nation's health care system, President Clinton proposed that VA compete with other providers to serve the health care needs of veterans. To be a viable competing provider, VA needs to quickly restructure its outpatient care delivery system to provide more timely ambulatory services. In doing this, VA should focus on developing systemwide patient-oriented processes, such as the establishment of telephone assistance networks and appointment scheduling systems, for veterans who have nonurgent conditions.

The Secretary of Veterans Affairs generally agreed with GAO's findings and conclusions. The Secretary recognizes that the efficiency of VA's outpatient facilities can be improved and has expressed a commitment to implement the corrective actions that GAO recommended.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the timeliness of care veterans receive in the more than 200 outpatient facilities operated by the Department of Veterans Affairs (VA).

During your July 1993 hearing, we reported widespread inconsistencies in access to VA outpatient care.[1] Veterans with similar medical conditions and economic status were receiving care at some centers but not at others, due primarily to differing interpretations of statutory eligibility rules. At that hearing, veterans' service organizations expressed concern that veterans who gain access to VA care frequently face lengthy waits before receiving needed services.

As you know, this was not the first time that concerns have been voiced about the timeliness of VA's outpatient care. For example, during a 1991 hearing before the House Committee on Veterans' Affairs, witnesses testified that VA's system was not well suited to meet veterans' needs. In response to concerns voiced at the 1991 hearing, you asked us to examine VA's ambulatory care system to determine how long veterans wait for care, identify factors causing service delays, and recommend ways to shorten veterans' waiting times. To do this, we focused on VA's emergency/screening clinics, which are the entry points for veterans seeking care, and specialty clinics, such as those for cardiology or orthopedics, which provide care for more complex medical conditions.

As we reported to you in mid-October,[2] veterans too often encounter lengthy waits for care in VA clinics. Veterans being served in the more than 200 emergency/screening clinics we surveyed frequently waited 1 to 3 hours or longer before physicians examined them for nonurgent conditions. In addition, veterans waited 8 to 9 weeks, on average, for appointments to the more than 700 specialty clinics we surveyed.

Inefficient operating practices are the major contributors to veterans' service delays. These practices result in many veterans with nonurgent conditions arriving unscheduled at emergency/screening clinics and receiving care on a first-come, first-served basis. This, in turn, often results in uneven workloads for staff at the clinics and overcrowding during peak hours. Also, VA operating policies allow many veterans to receive general medical care in specialty clinics after their medical conditions have been stabilized, thereby resulting in overcrowding of these clinics as other veterans needing specialty care are referred to the same clinics.

I would like to describe, in a little more detail, some of the major causes of service delays in emergency/screening and specialty clinics as well as approaches that facilities should consider to improve service delivery.

EMERGENCY/SCREENING CLINICS

VA's emergency/screening clinics follow standard procedures when providing ambulatory care to veterans. In general, veterans visit the clinics in person whenever they have new conditions they believe require treatment. Upon arrival, veterans must first check-in with a clerk and then go through "triage," where health professionals determine the severity of their conditions. Once this is completed, clerks process their applications for care and check eligibility. Veterans then wait for evaluations by physicians, generally being seen in the order in which they

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[1]Veterans Affairs: Accessibility of Outpatient Care at VA Medical Centers (GAO/T-HRD-93-29, July 21, 1993).

[2]VA Health Care: Restructuring the Ambulatory Care System Would Improve Service to Veterans (GAO/HRD-94-4, Oct. 15, 1993).

arrived, unless their conditions are considered to be emergencies.

During our visits to seven emergency/screening clinics, we saw first-hand many overcrowded conditions where veterans were patiently waiting for care. In addition, we gained a greater appreciation for veterans' concerns about the timeliness of VA's ambulatory care by reading hundreds of veterans' letters describing service delays that they had experienced. Through reviews of medical records, we learned that veterans frequently visited emergency/screening clinics to have routine medical questions answered about previously diagnosed conditions or about prescribed medications.

Too often, we found veterans waiting needlessly for general medical assistance that could have been provided much more efficiently by telephone or through a scheduled visit. For example, we identified many instances where veterans were required to travel to VA clinics, go through time-consuming clinic processing requirements, and wait to see doctors, merely to have their prescriptions refilled. It is no wonder that one veteran in a letter noted: "These days when I get ready to go to the VA I pack a lunch and take a book . . .."

These types of service delays occur because VA's ambulatory care system is not set up to handle most veterans' conditions efficiently. VA officials estimated that nearly three-fourths of the veterans who came to emergency/screening clinics had nonurgent conditions, meaning that they were neither life- nor limb-threatening and were not time sensitive. VA's ambulatory care system forces these veterans to walk in to VA's emergency/screening clinics regardless of their medical needs.

Our survey showed that only 18 percent of all visits to emergency/screening clinics were scheduled. Because nonurgent veterans are treated on a first-come, first-served basis, they tend to arrive in the early morning hours and overwhelm clinic staff. Officials believe that such uneven workloads contribute to long waits, dissatisfied veterans, and stressful working conditions for VA staff.

VA facilities have independently taken a variety of steps to reduce veterans' waiting times. A few facilities developed alternative delivery options, such as telephone assistance networks, that attempt to resolve veterans' problems by phone or through scheduled clinic visits. One facility reduced the volume of veterans walking in to the emergency/screening clinic by 18 percent after adopting a telephone assistance network. About 60 percent of nonurgent veterans at this facility waited less than 30 minutes for physician evaluations compared with 17 percent systemwide.

Another facility restructured its ambulatory care program using primary care providers as the cornerstone. Veterans are assigned to primary care providers who assure continuity of care from the time a veteran first applies for care. This facility decreased the number of veterans in the emergency/screening clinic and assigned nonurgent walk-ins to primary care providers at scheduled times.

SPECIALTY CLINICS

Veterans are usually referred to specialty clinics by emergency/screening clinic physicians or by their attending physicians at the time of their discharge from a VA inpatient stay. When a specialty physician evaluates a veteran, he or she may require that diagnostic or laboratory tests be performed. If necessary, the veteran is then given a follow-up appointment for a specialist to review test results, make a diagnosis, and start

necessary treatment. The specialist then continues to monitor the veteran's condition.

We reviewed several specialty clinic schedules and observed operations during our site visits. Too often we found that veterans had to wait several months to see specialists. VA staff told us that if a veteran's condition was urgent and an evaluation was needed before the next available appointment, the clinic would overbook the schedule to see the patient sooner.

These long delays frequently occur at specialty clinics because too many veterans continue to receive routine follow-up care in these clinics after their conditions are stabilized. Filling clinics' schedules with such patients contributes to long appointment waits for new patients. For example, at one facility we visited, a veteran was initially diagnosed in the cardiology clinic as having mild congestive heart failure. This patient continued to be given appointments every 6 months to the cardiology clinic for routine monitoring of his condition. This routine monitoring could have been done by a primary care physician, thereby freeing specialists to treat veterans needing evaluations of new conditions.

Facilities have independently taken a variety of steps to reduce appointment delays. For example, some facilities have reviewed the medical requirements of veterans being treated in specialty clinics. These clinics then transferred veterans needing only routine follow-up care for stable conditions to general medicine clinics. One cardiology clinic transferred 20 percent of its patients to its primary care clinic using this technique. This reduced waits for appointments from 1 year to 4 months.

Some facilities used primary care providers to coordinate specialty referrals. For example, two facilities we visited coordinated specialty referrals by allowing only primary care providers to make referrals unless emergencies arose. Using this gatekeeper approach, one facility decreased waits in specialty clinics to about 30 days.

NEEDED: RENEWED EMPHASIS ON PATIENT SERVICE

Mr. Chairman, in his recent proposal to reform the nation's health care system, President Clinton proposed that VA compete with other providers to serve the health needs of our nation's veterans. VA's ability to serve its patients in a timely way will be a key factor that veterans will consider when choosing a health care plan in a reformed health care system. VA has not, heretofore, placed sufficient emphasis on the need for timely ambulatory services to veterans as evidenced by the fact that it does not keep systemwide data on waiting times for care. Neither has it established Department-wide performance goals against which individual facilities' waiting times can be monitored and corrective action taken.

We believe that VA needs to restructure its ambulatory care delivery system to provide timely, patient-oriented services that meet veterans' varying health care needs. To do this, we recommended in our October 1993 report that VA focus on basic process changes, such as establishing telephone assistance networks and appointment scheduling systems to expedite veterans' access to care for nonurgent conditions. Moreover, VA needs to (1) identify the best practices in use at its different centers and develop a strategy for replicating them systemwide and (2) establish Department-wide performance goals to reinforce a renewed emphasis on reducing the time veterans have to wait for outpatient care.

From a veteran's perspective, having a single primary care provider who is familiar with his or her condition, who will be accessible for nonurgent problems, and who can coordinate any needed specialty care seems desirable. Such an approach will counteract complaints about fragmented and episodic care and can reduce waiting times in emergency/screening and specialty clinics. Again, a few facilities have experimented with this approach and the preliminary results seem encouraging.

The Secretary of Veterans Affairs commented, in an October 5, 1993, letter, that he generally agreed with the findings and conclusions in our October 1993 report. He stated that VA is developing a strategic planning goal to implement a managed care approach that focuses on primary care. Through this effort, VA expects to enhance services to veterans as well as address our recommendations.

In our view, VA is moving in the right direction. However, identifying the causes of service delays and reaching conceptual agreement on potential solutions may be the easier part of VA's task. Implementing the needed changes in a system as large as VA's will be a formidable challenge. This is because such implementation will entail shifting medical centers' ambulatory care emphasis from a specialty orientation to one focused on primary care and a corresponding reallocation of resources to make that shift happen.

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In summary, Mr. Chairman, VA has a responsibility now and in the future to provide the veterans of this country with timely health care. Clearly, it has some catching up to do. We think that our recommendations offer sound first steps towards meeting this responsibility. More importantly, overhauling the ambulatory care system--and doing it quickly--is essential if VA is to be a viable competitor under the President's health care reform proposal.

This concludes my prepared statement. We will be glad to answer any questions you and Members of the Subcommittee have.

(406070)

STATEMENT OF

TERRY GRANDISON, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

HOUSE VETERANS' AFFAIRS SUBCOMMITTEE

ON OVERSIGHT AND INVESTIGATIONS

CONCERNING

DELAYS IN THE PROVISION OF AMBULATORY CARE TO VETERANS

October 27, 1993

Mr. Chairman and Members of the Committee, Paralyzed Veterans of America (PVA) appreciates this opportunity to express our views on the Department of Veterans Affairs' ability to provide timely ambulatory care services to veterans. Over the past decade, medical models for the provision of clinical services have shifted greatly from inpatient modes of care to outpatient or ambulatory services. The results have been determined by a search for the most effective means of patient care as well as the desire to reduce the overall skyrocketing cost of providing those services.

The Department of Veterans Affairs has made efforts to adapt to new outpatient models. However, this process has been encumbered due to institutional, budgetary and administrative roadblocks:

- Existing veteran eligibility criteria continues to favor inpatient care as a preferred model for patient services by denying or rationing out-patient access to many veterans;

- Massive budget shortfalls over the past twelve years have forced VA to ration all areas of patient care, and have been particularly inadequate to support wholesale expansion of VA out-patient capability; and

- VA has failed to implement and follow guide-

lines and standards for the efficient and timely provision of outpatient care.

PVA has repeatedly expressed the concern to the Congress that these pressures on outpatient capability have greatly reduced the efficiency of the provision of services. Waiting times are the clearest indicator of the effectiveness of an outpatient operation. Waiting times, likewise, are the clearest indication of patient satisfaction or dissatisfaction with health care services and a health care system that provides those services.

VA, for whatever combination of the above circumstances, has amassed a poor record in providing efficient and timely services for veterans currently utilizing VA outpatient facilities. The recent report from the General Accounting Office (GAO), Restructuring Ambulatory Care System Would Improve Service to Veterans, and the September 30, 1993, report from the Office of the Inspector General (IG), Audit of Outpatient Waiting Times at Department of Veterans Affairs Medical Centers are the latest indications that many veterans continue to suffer inordinate, and in most instances, totally unnecessary delays in the provision of outpatient services. However, successive Independent Budgets over past years, published by AMVETS, Disabled American Veterans, Paralyzed Veterans of America and Veterans of Foreign Wars have repeatedly questioned the inadequacy of VA outpatient capability and inordinately long waiting times veterans must endure to obtain appointments for routine services as well as certain specialty clinics and procedures.

The IG and GAO reports cited above revealed two disturbing trends.

1. On average, judging from those VA facilities surveyed, waiting times for veterans in VA facilities were considerably longer than non-veterans would have experienced (and

more importantly, tolerated) in private sector facilities. The waits experienced by VA patients were consistently longer than waiting times prescribed by VA guidelines (which are not being implemented.)

2. Some VA facilities are dealing with this problem successfully on an individual basis. However, the system as a whole has failed to establish department-wide performance goals for timely service delivery. VA has also failed to establish a system that can gather the data required to allow each facility's performance to be measured against established goals.

These two reports underscore what many veterans feel is a cavalier attitude throughout the system that treats patients as though they were a commodity and not a valued customer. The inefficiency resulting in delays of treatment may be inadvertent or overt depending upon the individual situation. The recent reports indicated that block scheduling or, in certain circumstances, the lack of adherence to scheduling at all, resulted in veterans waiting hours just to receive certain routine services. Each of these instances makes its mark on the veteran patient, whether through increasing frustration, lost time away from work or just plain lost time. Each time this happens, the veteran reinforces an already deteriorating perception of the health system that provides his or her care. From that standpoint the system as a whole develops, and cannot overcome, a reputation for providing substandard care.

The health care reform plan proposed by the Administration gives the Department of Veterans Affairs Health Care System the ability to survive. However, it will not just be given that opportunity. VA can only survive if it is able to compete successfully with the private sector over patients, costs and quality. Currently the VA

health care system has a "captive" patient population. Veterans in most instances go to the VA to receive their care either because the system provides certain specialized services they cannot obtain elsewhere, or because veterans do not have the resources to cover the cost of care in the private sector. The Clinton proposal would give these veterans, for the first time, the choice to go elsewhere for comparable benefits. That choice will undoubtedly be made on the individual's assessment of the quality of the services his or her chosen provider can offer. If VA does not measure up in an individual veterans assessment, that veteran will seek care elsewhere.

Paralyzed Veterans of America is in the process of completing a nationwide series of professionally-conducted focus groups drawing from the broadest possible spectrum of the veteran population. The focus groups are intended to provide an overview of current veteran attitudes toward VA health care and an assessment of what the veteran consumer would expect, and require from a health care provider, whether it is the VA or a private sector plan. One theme has already become very clear.

Veterans, as well as the general population, when asked to assess quality of care make that determination, not so much on the qualifications of the provider, but on how they are treated when they seek medical care. For the vast majority of patients, the amenities of a health care system take precedence in the designation of patient satisfaction over the actual medical services provided. Reasonable waiting times, courteous staff, pleasant surroundings and the like equate to quality care.

Individuals expect that the diagnosis and clinical treatment they receive from a health care facility will be adequate to address their health care concerns. In this category VA is comparable, and even superior to its potential private sector competitors. However, it is the perception of the process in the provision of that care, either positive or negative, that an individual takes

with them when they walk out the hospital door as well. And in most instances, it is that perception that will dictate whether the patient returns to that facility or that provider for care a second time. In this regard, VA has a lot to prove to the veteran patient population. That proof should be offered whether VA is given the opportunity to compete for its patients in the context of health care reform or not.

Mr. Chairman, this concludes my testimony, I will be happy to answer any questions that I can.

STATEMENT OF FRANK C. BUXTON, DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
OCTOBER 27, 1993

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to present its views concerning ambulatory care services in the Department of Veterans Affairs (VA). This hearing is extremely timely and important. A thorough review of current VA outpatient care practices is absolutely critical as the VA prepares for the implementation of national health care reform.

Mr. Chairman, for a long time, The American Legion has been concerned about a reduction in the amount and timeliness of VA outpatient care. In the middle 1980s, access to outpatient care became more restricted as significant resource shortages were reported throughout the VA health care system. Today, almost all discretionary care veterans are unable to obtain VA outpatient services, and the mandatory care veterans have witnessed a lengthening in the time required to obtain scheduled appointments. This phenomena is much more pronounced in regard to subspecialty care. Within our experience this often occurs when the demand for services simply exceeds the resources to provide the care.

Despite workload restrictions for discretionary care patients, many VAMCs have seen a continual increase in their outpatient caseload without a commensurate increase in resources. At the same time, there are often operating inefficiencies. In private practices, most physicians rotate between several rooms, concentrating on patient evaluation and treatment. Many VAMCs have one physician assigned to one room, and that room may also be their office. Physician time is wasted because, out of necessity, they do clerical and clinical work that more appropriately can and should be done by clerks, nurses, or physician assistants. However, adequate support personnel often are not available due to staffing or space

constraints. Furthermore, clinic profiles are often overbooked. Too many patients are scheduled within a limited timeframe, creating longer waiting periods.

The Legion is aware that lengthy delays in obtaining scheduled appointments can lead to more serious health problems. We have recommended over the past several years that VA initiate a comprehensive preventive health care program to detect and treat the early onset of disease and illness. Due to extraordinary resource shortages, eligibility reform has not been possible and, without that reform, improved access to care and the timely delivery of outpatient services becomes more problematic.

As an added dilemma, patients often times travel long distances for scheduled appointments, only to incur lengthy delays or cancellations. The American Legion's health care proposal, An American Legion Proposal to Improve Veterans Health Care, calls for VA to move toward outpatient care and to provide facilities for overnight stays for outpatients at VAMCs. Many VA medical centers lack the ability to treat certain veterans as outpatients because of the need for special preparation or limited post-treatment monitoring and/or because the veteran lives far from the institution and there are no facilities nearby for overnight lodging. Overnight facilities for outpatients and their families exist across the nation in a network of "hospital hospitality houses" at little or no cost to the patient.

Due to the unique features of the VA health care delivery system, involving long travel distances and a lack of adequate ambulatory care treatment facilities, The American Legion supports programs which would provide affordable overnight facilities at or near VA medical centers. The Legion also recommends that any cost associated with such housing be minimal to discretionary patients and absorbed by VA in the case of treatment for service-connected illness or disability. The Legion further encourages its Departments and local posts to

participate in the organization, creation, funding and operation of such programs at local VAMCs.

It is unlikely that these concerns will substantially improve without VA receiving appropriate medical care funding, the complete revamping of patient eligibility rules, and placing a greater priority on preventive health care and primary care provider treatment teams. Overall, the Legion believes the President's health care reform plan for VA is a good starting point for correcting many of these problems.

Mr. Chairman, before VA can open its doors to all veterans under health care reform, it must be able to adequately manage the current workload. Some VA facilities are in various stages of developing a managed care primary treatment team model. This concept refers to a delivery system which focuses responsibility and coordination of patient care on a core unit Primary Care Provider (PCP) treatment team. The primary care provider is involved in the full continuum of care including intake, health promotion and disease prevention, patient and family health training and education, case management of acute and chronic medical and psychological problems. The specific PCP model developed for each VA facility will depend on the type of facility (rural, urban, affiliated, or non-affiliated) and its mission. The PCP model will hopefully create a customer/client focused relationship to enhance health care services, improve the delivery and quality of care, and provide VA with a foundation to compete in the health care marketplace. Some VAMCs have initiated the primary care provider treatment concept: VAMCs Boise, ID; Walla Walla, WA; Portland, OR; Little Rock, AR; Sepulveda, CA; Durham, NC; and Columbia, SC.

Mr. Chairman, The American Legion has reviewed the September 30, 1993, VA Inspector General report on Outpatient Waiting Times at the Department of Veterans Affairs Medical Centers. The American Legion deems it unthinkable that responsible officials at VA medical facilities are unaware of excessive outpatient waiting times. Regular management controls should be in place to monitor all clinic practices. It is the

responsibility of top management, medical administration personnel, and the Chiefs of Ambulatory Care Services to continually assess and correct all identified problems. Some factors identified by the VA Inspector General (IG) which contributed to the outpatient appointment delays, appear to be more closely related to ineffective management controls rather than to resource issues. The report only focused on scheduled outpatient delays. We think it follows that unscheduled appointment delays would also be found to be excessive.

Mr. Chairman, there are certain constraints placed on VA due to insufficient resources and personnel. We acknowledge that VA succeeds remarkably well in many clinical areas in spite of its institutional barriers. However, when patient care problems can possibly be remedied through direct staff supervision, we are troubled that they are not. It is unacceptable that only 56 percent of the veterans' records reviewed by the Inspector General were found to have been examined within a 30 minute waiting time. The IG report found that almost half of the patients, who had scheduled outpatient appointments, had to wait an average of 75 minutes beyond their appointment time. Many of the delays were identified for preventable administrative reasons. If VA is going to successfully compete in the arena of national health care reform, it must improve the timeliness of its health care delivery systems.

The American Legion believes efforts need to be made to coordinate the pending VA Strategic Plan, eligibility reform, the Veterans Service Area (VSA) concept and resource allocation so that all the wheels are moving in the same direction toward VA health care reform. In addition to implementing effective management controls on the timely delivery of outpatient care, VA must be provided sufficient resources to upgrade its existing hospital infrastructure and focus on expanding the number of community based clinics. The VA expects to move its emphasis from expensive inpatient care to outpatient services, prevention and primary care to hold down

costs by keeping patients healthy. Before full implementation of this philosophy is possible, much remains to be accomplished.

Under the President's health care reform proposal, more veterans and dependents will be eligible to be treated by VA. Adequate space, funds, personnel and equipment are essential for VA to compete in a reformed health care environment. Complete planning for ambulatory care clinical expansion projects to correct service space deficiencies and expand outpatient programs is essential. Enhanced computerization in the ambulatory care setting in the management of patient scheduling, and the tracking and trending of patient care activities, would improve overall efficiency and enhance the ability to monitor clinical indicators. Increased medical administration and secretarial support staff will be required to better integrate the patient workload. A proper mix of clinical, supervisory, and administrative support staff is basic to a well functioning ambulatory care department.

Mr. Chairman, it is time for VA to look at restructuring its ambulatory care delivery system. More patients and more programs have been added over the years, yet little change has occurred in the ambulatory care organizational model. Outpatient scheduling must improve, more effective management controls must be in place and followed, additional personnel and greater ambulatory care space is required, waiting times for obtaining a subspecialty clinic appointment must be reduced, and the current figures on the percentage of veterans who have their scheduled appointments within the 30 minutes prescribed by VA policy must improve dramatically. The American Legion believes all of these measures can and must be accomplished.

Mr. Chairman, on October 8, 1993, Senator Jay Rockefeller stated, "It is absolutely essential that the VA health care system reallocate its resources to improve access to outpatient treatment and primary care." On October 13, Secretary Brown testified before the Senate Veterans Affairs Committee that, "We will have to expand the scope of our medical care delivery system to provide basic primary and ambulatory care services".

The American Legion could not agree more. At a recent VA seminar in Tampa, FL, the clinical leaders of ambulatory services in VA made a number of astute and critical observations about the way VA delivers ambulatory care. This group, with input from The American Legion, made a series of strong recommendations to the Secretary regarding methods to improve primary care services and ambulatory care. It is important that critical resources be allocated and that these recommendations be implemented post haste.

From all observations, everyone agrees that the delivery of ambulatory services in VA must undergo change and that change must occur now. Secretary Brown has adopted the motto of "Putting Veterans First." The American Legion believes that philosophy should extend to all operations within the Department of Veterans Affairs. With regard to the delivery of ambulatory services, we know what's wrong, we have expert recommendations to fix it, let's move ahead with it!

Mr. Chairman, that concludes our statement.

Vietnam Veterans of America, Inc.
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STATEMENT OF

VIETNAM VETERANS OF AMERICA

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Before The
House Veterans' Affairs Subcommittee On
Oversight and Investigations

On

Timeliness of VA Outpatient Health Care

October 27, 1993

TABLE OF CONTENTS

Introduction

Mr. Chairman and members of the subcommittee, Vietnam Veterans of America (VVA), appreciates the opportunity to present its views on the timeliness of outpatient health care offered by the Department of Veterans Affairs (VA). We view this as one of the central issues among the consumer-friendliness problems that VA must address in order to be a viable competitor within a national health system.

Arguments can certainly be made that VA provides quality care, but dwells under the close scrutiny of negative press because of certain high profile incidents. The fact is, however, that the determining factor in whether or not VA will survive the competition of national health reform, is how veteran users feel about the care they receive at VA -- not the quantity of statistics the VA bureaucracy can publicize telling of private sector comparable Joint Commission on Accreditation of Healthcare Organizations (JCAHO) evaluations and mortality rates. Excessive waits for scheduled outpatient appointments definitely contribute to veterans' negative perception of VA health care.

VVA is very pleased by what we have seen of the President's health care reform proposal thus far. If this proposal becomes law, VA will be given every opportunity to "sink or swim" in a competitive environment. Veterans will be provided a choice of where to obtain care, and will have access to the full range of health services. We are also encouraged by some of the steps taken recently by VA to begin planning for the advent of a competitive health care arena. Secretary Brown's comments last week, presented before both the House and Senate Veterans' Affairs Committees on this very issue of timeliness, indicate that there is finally realization within the VA that this mammoth bureaucracy is supposed to operate <u>for</u> the veteran users. We are hopeful that this watershed health reform activity will provide the impetus to improve services such that veterans <u>will</u> choose to receive care at VA.

In the meantime, there is room for improvement in the timeliness of VA outpatient care, both in scheduling an individual appointment and after the veteran arrives in the VA waiting

room. VA needs to change its image prior to the implementation of national reform, in order to induce veterans to choose VA as their health provider. Otherwise VA will lose patients who know they can access care more easily from a local provider.

We commend you, Mr. Chairman, for holding this hearing to address the excessive appointment waiting times at VA outpatient clinics. VA's future as a health provider for veterans depends upon its ability to address this critical consumer-friendliness issue.

GAO & IG Findings

The recently released General Accounting Office (GAO) and Department of Veterans Affairs Office of Inspector General (IG) reports on this issue reveal exactly what veteran service organizations and your constituents have been saying all along: veterans have to wait far too long for VA physician appointments. Nearly half, in one study, waited half again as long as VA policy says they should. This problem can be a severe deterrent for a veteran seeking care. Eventually many give up on the VA and make private expenditures to see a local provider, or worse yet they do not get needed care.

Granted, VA has staffing problems resulting from budget shortfalls in recent years which fail to meet new demand for services. We do agree with the recommendations put forth by both the GAO and the IG, however, indicating that certain steps should be taken to improve management of this problem aside from simply adding additional staff. More Veterans Health Administration (VHA) Central Office guidance and control of the outpatient facilities could enhance efficiency. Positive role models cited in the GAO report are evidence that the application of some ingenuity can truly improve services.

First, the VHA should provide facility directors with effective methods of measuring waiting times. Although Congressional leaders and veterans service organizations have relayed complaints about appointment delays for years, many facility directors do not evaluate this important factor of patient satisfaction, and therefore are not aware of the existing problem and

do not take corrective action. Other facility directors do evaluate waiting times, but fail to report the results to the Central Office.

Subsequently, Central Office should establish and measure timeliness goals. As things are now, facilities may set their own goals, and thus timeliness varies widely from clinic to clinic. Facilities are also at their own discretion to monitor compliance with timeliness goals, and often fail to do so.

Clinics should utilize appointment schedules to manage the workload -- many do not -- and should do so in a manner that is convenient for the veteran patients to avoid "no-shows". The IG finds overbooking of appointments one cause. We all hear stories from the field of veterans who miss their outpatient visits because they simply forgot about appointments scheduled six months prior. They must then wait another six months for a new appointment. Doctors in the private sectors cut down on "no-shows" with routine reminder calls a day or two ahead of appointments.

One of our members recently told us of a visit to one of the better VAMCs that typifies the problems of user-unfriendliness and timeliness. After waiting several hours for an interview with a doctor about Agent Orange screening, he had a friendly meeting. They both had similar service backgrounds, took a liking to one another, and so on. Finally the doctor took him out to the nurse and asked her to schedule a test for him at his convenience. The phrase did not compute. The doctor repeated it, and went on to another patient. After the test was scheduled, as our member walked towards the elevator, he heard the nurse muttering, "At his convenience! At his convenience!"

There are also tenets of current private sector managed health care that VA could utilize to become more efficient in its outpatient appointment timeliness. Some facilities have already begun to do so, as the GAO report notes. VA outpatient clinics should utilize a primary care emphasis, managed care approach to regulate which patients utilize specialized clinics and services, thereby reducing waits at specialty clinics which are overburdened providing routine

care. Cost-effective outpatient care should be emphasized when inpatient care is not needed or desirable. Along with this, implementing a program of phone assistance can prevent unnecessary doctor visits, also reducing waits for other veterans.

Eligibility Reform Must Equal Entitlement

Another factor which delays VA outpatient visits is, of course, the eligibility checks which verify the veteran's service record, disabilities and income. We fully realize that it is impossible for VA to implement eligibility reform to a degree that would provide satisfactory openness to the full range of care for all veterans, without the additional benefit of national health reform. VA fears being flooded by veterans seeking health services who are currently unable to obtain private sector care for a variety of reasons. Because resources simply are not available, we have the current myriad of access rules.

VVA has consistently advocated that eligibility reform be enacted to simplify the myriad of eligibility criteria, and certainly the advent of national health system reform will make this imperative. We believe that veterans will walk away from the VA's complicated eligibility-based admissions -- running instead to the easier-to-access national health care system where they can receive the full continuum of care on a medically appropriate inpatient or outpatient basis -- and will never return. This will hold true unless VA eligibility reform is enacted from day one of the national health system.

Never before was comprehensive eligibility reform fiscally desirable, as the current maze of restrictions have served as the floodgates holding back demand for health care services by veterans who have no other health care options. National health care reform will give these veterans another option, however, and reports by GAO and the Paralyzed Veterans of America attest that it is doubtful that large numbers will still wish to use the VA. Open eligibility will be required to sustain sufficient patientload demand on the VA to keep it from becoming a ghost town, and should be tailored to attract those veterans the VA serves best. These populations of veterans are the aging, blind and spinal cord injury patients, veterans needing prosthetics, long-

term mental health and PTSD treatment, substance abuse programs, among other suitably selected populations.

The Clinton national health care reform plan seems to give service disabled and low income veterans an "entitlement" to care in the VA. Certainly the plan views overall health care as an "entitlement" for all Americans, and does make special provision for those who have sacrificed personal safety while serving in the armed forces. All otherwise non-entitled veterans will be able to choose the VA provider plan if they wish. None will be barred from entry, and they may be able to arrange VA care for dependents for the first time.

VVA is very hopeful that the VA health system will compete successfully under health reform. The President's plan seems to provide all the tools necessary for it to "swim". But someone needs to stand up and ask, "what if VA sinks?" Then what becomes of the veterans with special health care needs for which the private sector has simply not been forthcoming (such as PTSD, prosthetics and spinal cord injuries)? Will service-connected veterans still be able to get cost-free care? How can this be provided without the VA? We recommend that Congress consider establishing a "service-connected veterans health care entitlement" -- just as the elderly and disabled are entitled under medicare -- to ensure that this nation upholds its commitment to veterans whether the VA prospers or goes the way of the Canadian system. Should VA healthcare disappear from the national health landscape in, say, ten years, it will be far more difficult for fiscal reasons then to create an entitlement than now.

Faulty Central Office Management

As we indicated at the previous hearing on VA outpatient eligibility, part of the problem facing the VA is its failure to effectively coordinate management responsibility between the Central Office and local VA facilities. Currently, the sprawling system that is VA health care as we know it consists of 171 hospital and satellite outpatient fiefdoms free to provide or not provide whatever they wish, to whomever they wish, whenever they wish and without effective controls or guidance from VA Central Office. VA Central Office apparently believes it can

manage this system by relying upon its regional health bureaucracy.

A more appropriate division of responsibility would give Central Office managers the authority to mandate the minimum mix of services, as well as standards of timeliness and appropriate delivery, to be provided in both VA medical centers and outpatient clinics. Certainly, local facility managers are in the best position to determine the needs of the local VA-dependent population of veterans. These managers should submit to Central Office their proposals for meeting the needs of local VA-dependent populations so that local conditions can be appropriately weighed by Central Office when resource allocation decisions are made. Moreover, VA Central Office must be in a position to assure itself that what the field is asking for is indeed what is needed by veteran users. The importance of appropriately balancing management responsibility between Central Office managers and local facility caregivers takes on added significance with national health on the horizon. Most obviously, this is because the VA intends to hold itself out as a care provider that current non-users of the system will find attractive and be willing to subscribe to, instead of care options managed by the private-sector.

Countless cases come to our attention from the field of veterans who are turned down for outpatient care because the clinics are full, because the physician will not see them, or because the services they need are not provided at that particular facility. Sometimes they are given care on one visit, and are turned away from the same services on follow-up visits. Often service-connected and low-income veterans are denied basic services, while the same facility provides more specialized services to all veterans regardless of income. On occasion, a VA physician will admit a veteran as an inpatient in order to provide needed services which the veteran is not entitled to receive on an outpatient basis. Veterans who object to how they are being treated risk losing their quasi-eligibility if the local facility decides not to treat them any longer. And sometimes eligibility is denied through attrition, when waiting times are so long that veterans simply give up and go home.

Standard, logical business practice and provision of medical care should be mutually consistent even in the government, and dictate that centralized management standards utilize

budgeting and resource allocation to make its operation as cost-effective as possible. VA Central Office needs to shift resources to meet demand, so medical centers can produce services where they are most needed, and purchase services from non-VA providers where economies of scale cannot be established. With national health reform, cost-effective outpatient care will be in far more demand that expensive inpatient care. It will be vital for VA to reallocate resources toward this premise and fill the void of rural health by assuming this mission which is neglected by private providers.

Certainly, from a management perspective, this sort of massive coordination is a huge and difficult task to undertake. Isn't this the purpose and advantage, though, of having such an agency as the Veterans Health Administration? If this means taking personnel and/or equipment out of a facility where it is underused, to be placed in another where it will be used efficiently, so be it. If this means providing fee-for-service cards to eligible veterans or transferring them to other VA facilities because the specific services they need are not provided locally or the time and space to provide this treatment are not available in the nearest facility, so be it.

Quality as Defined by the User

Today veteran users of VA health care are essentially condemned to a system that many cannot easily get to, that they must wait excessively to use, and that they would choose not to use if a choice were available. The main reason a veteran would use non-VA health providers is that, rightly or wrongly, veterans think the quality of VA health care is seriously deficient compared to the private sector. This raises the important question of how quality is defined and by whom. The VA today measures quality according to the preferences of teaching institutions, researchers and bureaucrats. Nowhere is quality as defined by veteran users addressed in any meaningful way. Were it otherwise, the VA would have long ago realized that the hurdles to which it subjects VA-dependent users has made the VA decidedly consumer-unfriendly.

Fortunately, recent statements by Department officials indicate that this attitude is changing. VA now admits that it needs to address its consumer-friendliness and its image, and

does not simply complain of inadequate funding.

Often, the VA defends the quality of its product by comparing its health outcomes with those of private sector facilities. From a consumer's perspective, this is a false measure of quality, because it ignores what happens from the time a patient enters the door of a hospital or outpatient clinic to the time the patient is discharged. People like seeing the same doctor. Veterans using the VA typically see different doctors/students at each successive visit. Typically, VA patients believe that the VA treats them less professionally, less courteously, more invasively, less comfortably, less conveniently, with less privacy and discreetness and in a less timely manner than private care. Simply getting in the front door of a VA inpatient or outpatient facility has become so daunting and so frustrating that ease of access must also be seen as an important component for improving the quality of care provided at VA Medical Centers and outpatient clinics.

Conclusion

Mr. Chairman, VA serves three kinds of veterans now. It serves those whose service-connected problems cannot be served as well by less-specialized private facilities. It also serves those with service-connected problems who cannot afford to go to private facilities. And it serves indigent veterans with non-service-connected health needs. Once health care reform offers them a choice, the latter two kinds of veterans may leave for more convenient and friendly care.

Ask why so few middle-class veterans use the VA, in a time of tight dollars when every magazine and newspapers carries an article on how hard-pressed the middle class is. An article in the October 11, 1993 issue of Modern Healthcare puts it well in saying that middle-class veterans without service-connected disabilities are what the VA must attract to thrive in a competitive environment, and the VA does not attract them. Yet nobody tosses away free health care unless they think it isn't worth using. VA is a brand name with a poor reputation.

Until VA learns to make even minimal efforts for the patient's convenience, the system

itself will remain at risk in the face of health care reform that offers free choice. This capable but unwelcoming system must stop relying on a clientele who are prisoners of war wounds and economic disadvantage. Unless that happens, the VA will lose those veterans who do not need specialized services, and those who do will find the system they need collapsing about them.

Mr. Chairman, this concludes our testimony.

SERVING
WITH
PRIDE

STATEMENT OF

MICHAEL F. BRINCK
AMVETS NATIONAL LEGISLATIVE DIRECTOR

Before the
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
of the
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

On
IMPROVING
THE TIMELY DELIVERY
OF
VA OUTPATIENT CARE

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Wednesday, October 27, 1993
Room 334, Cannon House Office Building
8:30 a.m.

Mr. Chairman, thank your for inviting AMVETS to present testimony today on timely access to VA outpatient care. This is an important issue and central to VA's ability to compete in the administration's national health care reform plan. Timely access to medical care has several components.

First, VA's physical plant must be overhauled to enhance geographic accessibility. That means VA must begin to shift its focus away from medical centers and place a larger share of its resources in community-based settings. In a competitive environment, proximity will play a significant role in determining a veteran's choice of health care provider. We understand VA is staffing a plan to establish several hundred new community-based clinics as well as other initiatives to decentralize health care delivery. While we do not know the details of VA's plan we look forward to its introduction and hope this committee will give it rapid consideration. More importantly, we hope you will support decentralization through the appropriations process.

Second, as a new member of the competitive service sector, VA must have some flexibility in its personnel decisions -- especially in the area of its ability to rid itself of employees who are not attuned to the old saying that "the customer is always right". Too often we hear stories about veterans being treated with contempt by VA employees. There is a common theme in these stories; that veterans at VA hospitals are freeloaders and should be satisfied regardless of how they are treated because they get free treatment.

AMVETS knows that is not how this committee feels and it is certainly does not reflect the attitude of senior VA management. Usually, it is the most junior employees who display this attitude and whether they are mirroring the attitude of supervisory personnel or have not been properly trained in customer relations is immaterial.

The point here is two-fold; first, these are usually the first VA employees encountered when accessing the system. Thus, they form the veterans initial impression of the VA medical system. Second, if VA cannot expeditiously remove non-performers, these people will have the power to frustrate any management initiatives to improve VA's image with veterans and the general public. AMVETS asks Congress to provide VA with the latitude to reward its good employees and fire workers who resist the changes necessary to compete with the private sector. Simply, if an employee's performance would result in a termination in the private sector, the same penalty should be available to public sector managers.

AMVETS does not mean to imply that all VA employees have an attitude. But fixing VA's image is going to be a major undertaking. We urge the committee to look closely at comprehensive legislation that will allow VA to do many of the things needed to compete for business, such as advertising, that current law prohibits.

Third, the myriad reasons for today's long waiting lines can all be traced to underfunding. Since Congress provides the funds for facilities and staff to get the job done right, this body bears the major responsibility for the flat funding profiles that have characterized recent VA budgets and the system's current inadequacies. Recent administrations also share a portion of the blame for not placing a high enough priority on veterans health care.

Without adequate funds, VA cannot hire the staff, renovate old facilities, build new ones or purchase supplies and equipment necessary to provide quality medical care in a timely fashion. Delayed care is not quality care.

AMVETS has reviewed the recent studies of access delays done by the General Accounting Office and the VA Office of the Inspector General (IG). While the findings quantify the frustrations often felt by veterans, there was really nothing newsworthy. AMVETS and other veterans organizations have been testifying regularly to the long waiting times. We concur with the findings in the IG study. Overbooking, block scheduling, insufficient appointment time allotment, lack of adherence to schedule priorities and late arrival of physicians are all relatively easy fixes. So are monitoring average waiting times and periodically reviewing the scheduling practices of local managers. One of the findings by GAO was interesting. The report stated that a facility had reduced waiting times by 80 percent by reorganizing processing requirements. That is a significant reduction. But why were all other similar facilities not directed to implement these changes? Isn't that the job of any system with centralized policy development and decentralized execution? Why does it take so long for a good idea to get wide application?

More interesting than a compilation of average waiting times that merely confirms previously supplied anecdotal information would be an analysis of the management process at the Veterans Health Administration (VHA). Why is it there is so much diversity in the operational policies of medical centers? What is it about the system that seems to defy standardization?

Mr. Chairman, AMVETS would like to make one final point. I'm afraid what we have done here today is to continue a long series of hearings devoted to VA-bashing. In the coming

competitive atmosphere, it will be necessary to continue oversight to ensure effective use of taxpayers' dollars. But it is time to begin emphasizing what is right with VA medicine or VA will not be able to compete. The nation will lose a valuable health care asset and all of us here will bear a share of responsibility for that demise.

If the members of this committee take nothing else away from today's hearing, AMVETS hopes you will remember that Congress and the administration are the only ones who can make this work. It takes money, and you are the only ones who can provide those resources. That completes our remarks.

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
U.S. HOUSE OF REPRESENTATIVES
OCTOBER 27, 1993

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than 1.4 million members of the Disabled American Veterans (DAV) and its Women's Auxiliary, I want to take this opportunity to extend our appreciation for the opportunity to express our views of the Department of Veterans Affairs (VA) ability to provide outpatient care and services in a timely and quality fashion.

I would say at the outset, Mr. Chairman, the DAV shares your stated belief that, "... veterans can benefit from a competitive VA and that VA can compete successfully to serve the health care needs of veterans."

With respect to the timely provision of ambulatory care, the VA's Office of Inspector General (IG) has issued an audit: "Outpatient Waiting Times at Department of Veterans Affairs Medical Centers," dated September 30, 1993. Also, released on October 19, 1993, was a General Accounting Office (GAO) report: "VA Health Care: Restructuring Ambulatory Care System Would Improve Services to Veterans."

Mr. Chairman, both documents, which we will address individually, conclude the manner in which outpatient care is provided to veterans causes; excessive delays in receiving examinations and treatment; inordinate waiting times, occasionally more than six hours before a veteran sees a physician; excessive periods of time to schedule clinic appointments; and, general inefficient operating practices. These and other factors contributed to veterans not being provided adequate, timely and quality outpatient care services.

Mr. Chairman, while the contents of both the IG and GAO reports are detailed, extensive and revealing, quite frankly, they come as no surprise. Rather, their findings are predictable. The DAV, as well as other Veterans' Service Organizations (VSOs), have long recited the inequities and inefficiencies confronting veterans when attempting to gain access to VA outpatient care.

Additionally, the Independent Budget (IB) (coauthored by AMVETS, DAV, PVA, and VFW) has long made mention of and included findings relative to inefficiencies in the ambulatory care program. Of significance to the IB's mention of these problems is the fact they were brought to light by telephone surveys of medical center directors, clinicians, as well as other VA program officials. It is with some certainty and predictability that we proffer similar findings will continue to exist without major, radical changes in the way VA goes about the business of delivering health care to veteran patients.

Mr. Chairman, it is not our intent to cast blame or point fingers at any one particular entity within the system that has led to and perpetuates these problems to exist. Rather, we believe it necessary and, of course constructive, to offer what we believe to be credible suggestions and solutions that have as their goal establishing policies, procedures and practices that

would allow VA to enter an era of establishing current, state-of-the-art and competitive health care delivery systems.

Mr. Chairman, the stated purpose of the IG Audit was to determine whether veterans with scheduled outpatient appointments at VA medical centers waited an excessive length of time before receiving examination and/or treatment.

The Audit revealed that of 1,259 veterans sampled at four VA Medical Centers, 551 (44 percent) experienced excessive waiting times before being examined or treated for a scheduled appointment. These veterans waited in excess of the VA's accepted 30 minutes expected waiting time as set forth in VA policy. The average waiting time was approximately 75 minutes, or two and one-half times the established acceptable waiting time.

The Audit revealed five clearly identifiable practices which contributed to the identified excessive waiting times:

* excessively overbooking appointments;

* block scheduling of appointments;

* alloting insufficient treatment time per appointment;

* not adhering to the priority order in appointment schedules; and

* delaying the start of clinic operations due to the absence of physicians.

An additional finding of concern is excessive waiting times were not readily identified due to an absence of locally established management controls. None of the medical centers audited had implemented any management tools to monitor patient waiting times or update various clinic profiles.

As a result of the identified problems and lack of management controls, veterans were routinely inconvenienced, subjected to very congested clinics with a probable outcome of many veterans being discouraged from seeking needed medical attention from the VA. Such a situation results in veterans not receiving the care they need or abandoning the VA health care system in favor of seeking care from more accessible sources.

With respect to the GAO Report, the stated purpose was to:

* determine how long veterans wait for care;

* identify factors causing service delays; and

* recommend ways to improve efficiency and shorten veterans' waiting times in ambulatory care clinics.

Mr. Chairman, as previously stated, the GAO Report is extensive, extremely comprehensive, detailed and includes many recommendations that will, if implemented, go a long way toward ensuring VA's strengthening of its ambulatory care programs.

The significant results of the GAO Report are:

"Veterans are too often experiencing lengthy service delays when they seek ambulatory care at VA facilities. Although waiting times varied widely, veterans with nonurgent conditions frequently waited 1 to 3 hours before a physician examined them in the emergency/screening clinics that GAO surveyed. In addition, veterans

frequently waited 8 to 9 weeks to obtain appointments in the specialty clinics surveyed.

Inefficient operating practices are major factors contributing to veterans' service delays. VA's ambulatory care procedures cause many veterans with nonurgent conditions to arrive unscheduled at emergency/screening clinics and receive care on a first-come, first-served basis. This frequently results in uneven workloads for staff and overcrowding during peak hours. Also, VA's operating policies allow many veterans to receive general medical care in specialty clinics after their medical conditions have been stabilized, thereby resulting in overcrowding as other veterans with new conditions that need specialty care are referred to these clinics.

VA's reliance on local facilities to identify and address service delays has resulted in facilities trying a wide range of measures, with varying levels of effectiveness. Most facilities adjusted resources to address overcrowding, generally moving staff among service areas during peak periods. While this action may temporarily reduce service delays, it requires staffing to be continually adjusted in response to uncontrolled, fluctuating workload demands. Some facilities have achieved greater success through process changes, such as telephone assistance, networks, which allow workload demands to be more efficiently managed.

VA Headquarters has not provided (1) guidance on how veterans' waiting times should be measured or (2) performance goals to evaluate timeliness of services. Because systemwide goals have not been set, facilities have no bench marks against which to compare performance.

Mr. Chairman, the principal findings as outlined by GAO are:

Service delays stem from various causes. First, VA's ambulatory care system forces veterans with nonurgent conditions to use VA's emergency/screening clinics regardless of their medical needs. Many veterans have needs that could be solved over the telephone, such as advice about prescriptions or previously diagnosed conditions. However, these veterans have no option but to walk in for advice.

Second, nonurgent veterans are treated on a first-come, first-served basis, rather at a scheduled visit. As a result, they tend to arrive during peak hours, generally in the early morning, and can overwhelm clinic staff. Officials believe such uneven workloads contribute to long waits, dissatisfied veterans and stressful working conditions. Also, VA has not systematically identified bottlenecks in service delivery or established Department-wide performance goals for key processing steps.

Most VA facilities have independently taken steps to reduce veterans' waiting times. Some have adjusted service delivery options by evaluating processes and patient flows. For example, one facility reduced waiting times by more than 80 percent by reorganizing the processing requirements. Others have developed alternative delivery options that attempt to resolve problems by telephone or through scheduled visits to general medicine clinics. One facility reduced the volume of walk-in veterans by 18 percent after adopting a telephone assistance network. At this facility, 60 percent of nonurgent veterans waited less than 30 minutes for a physician evaluation compared with 17 percent systemwide.

Another facility restructured its ambulatory care program using primary care providers as "gatekeepers." Veterans are assigned primary care providers, who ensure continuity of care and coordinate speciality referrals. This facility decreased the number of veterans in the emergency clinic and assigned nonurgent walk-ins to primary care providers at scheduled times.

SPECIALITY CLINICS SERVICE DELAYS

Long delays frequently occur in speciality clinics because many veterans receive routine follow-up care in these clinics after their conditions are stabilized. Filling clinics' schedules with such patients contributes to long appointment waits for new patients. Also, missed appointments may extend appointment waits for many veterans. To compensate for missed appointments, facilities overbook scheduled appointments.

Facilities have tried to reduce overcrowding and long waits in speciality clinics by adjusting staff resources or clinic schedules. Some facilities have begun reviewing the medical requirements of veterans being treated in speciality clinics. Clinics then transferred veterans needing only routine follow-up care for stable conditions to general medicine clinics. For example, one cardiology clinic reduced waits for appointments from 12 months to 4 months using such techniques. Some facilities use primary care providers to coordinate speciality referrals. One facility decreased waits in speciality clinics to less than 30 days.

As we have indicated, Mr. Chairman, the GAO's report is extensive in its scope, findings, conclusions and recommendations. It can be generally stated that the DAV is in agreement with their findings and conclusions, and is supportive of the recommendations made.

As we indicated earlier in our testimony, Mr. Chairman, the findings of both the IG and GAO in their recent scrutiny of the VA's Ambulatory Care Programs is not only not surprising, but, rather quite predictable. In large part, the fault lies in the system. It continues to be our belief that VA is extremely well positioned to enter an era of health care reform in a manner that will match or exceed the expectations of those who ardently believe health care reform is vital to the nation. The VA possesses the facilities, physical plant, personnel and patient mix to make this happen. Additionally, the level of expertise and potential expertise VA possesses in the treatment of veterans for a full continuum of care is unmatched, as a system anywhere in the world. The potential for VA to "hit the ground running" is extraordinary.

The ingredient that seems to be missing at this point is a well-defined and thought out series of mechanisms that will put the VA on the path to success and excellence.

Mr. Chairman, so long as situations exist that produce findings as contained in the IG and GAO reports, VA will have a difficult, if not impossible, time convincing veterans to enroll in their health care system once a choice is available. Such difficulties lie in great degree to perceptions. What good is a system that provides the most state-of-the-art facilities, surroundings, equipment and health care providers if a veteran is unable to access the system to avail themselves of such expertise? In large part, this is the situation that currently exists.

Mr. Chairman, veterans cannot readily access and use the VA health care system because VA is not uniformly and systematically "user friendly."

The DAV certainly agrees that the process of change in a system such as VA's is a monumental undertaking. Health care reform will be a monumental perhaps decade long process. VA is not spared from such a process. There is a great and compelling need for the VA to utilize the best minds of the system in order to come up with policies, procedures and innovative methods to launch the VA into health care reform and keep it on a steady, focused course.

However, the DAV is fearful that if changes are not made immediately, then the window of opportunity will be slammed shut and lost. If VA cannot make changes today they may not have the opportunity to make them later.

Many of the changes required and outlined by the IG and GAO require little more than a commitment and a will to do. For example, VA clinics need to be open and available to veterans when needed. If VA is to be an attractive health care provider, they must extend their hours of operation into the evenings and on the weekends so veterans who so choose can avail themselves of treatment. By this we do not suggest skeleton crews would staff the clinics but, staffing would be adequate to meet the actual and projected workloads.

Mr. Chairman, the current structure and very location of VA clinics needs to change. The DAV is supportive of H.R. 3108, introduced by the distinguished member of the House Veterans Affairs Committee, Mr. Smith, that would significantly and meaningfully expand the scope of services provided in Vet Centers. In short, Vet Centers, as a physical plant, would be available to house health care providers in order to provide basic primary, preventive and screening procedures to veterans. Vet Centers have a proven track record of being "user friendly." They are located where veterans are. Veterans use these facilities and it makes imminent sense to utilize, where appropriate, Vet Centers as an entry point into the health care system for veterans.

In the same vein, VA needs to move now into the era of community based health care clinics. These need not necessarily be fully and expensively equipped facilities but rather exist at a location convenient to where veterans reside so they can, when needed, use VA in an easily accessible manner.

Mr. Chairman, the two reports at the center of today's hearing are actually nothing more than a continued identification of and validation of issues that exist within the VA health care delivery system.

From a pragmatic view point, the components that form VA's strengths also cause issues to exist that present very real obstacles to VA that, if not overcome, may effectively preclude them from succeeding in an era of health care reform.

The salient point we wish to stress today is the absolute critical need for VA to do something immediately. The issues have been identified and discussed by all who have an interest in VA health care. However, not much in the way of change has been seen as of yet.

It does little good to continue to discuss issues that need not discussion but require action. Seemingly, there is an inbred resistance to change. The traditional manner in which health care has been practiced in VA causes resistance to change. It is this mindset that must be addressed and altered.

Mr. Chairman, our testimony is not intended to imply that it is only VA being referred to. Indeed, just the opposite is the case. Many other entities have vested interests in VA and play a part, however well intentioned in VA's inability to change.

The VA does not necessarily need additional task forces to be formed to determine what needs to be done. What is needed is definitive action. The clearly identified, and we believe easily achievable changes, noted by GAO need to be implemented. It escapes us why, when one VA facility institutes a program that produces positive changes for veterans, such a program cannot be replicated by some or all other VA facilities.

Perhaps the answer lies in a lack of will to do so. Phrases like, "we're looking at," or "we need to think about," need to be replaced with actions.

The VA is a good system, Mr. Chairman, one we all seem to agree deserves to be given the opportunity to remain. The President's health care reform proposal gives VA that chance. We, as believers in the virtues of the system, must now make the commitment toward preserving the system. To do so necessarily entails change.

Change that will be good for veterans must be the cornerstone of the VA. It is long past time to consider any parochial issues that often equate to what is good only for the system.

Mr. Chairman, in conclusion, I wish to discuss one key issue affecting VA, that of the next Under Secretary for Health. As you are well aware, the Search Committee, or as it is known, the Under Secretary for Health Commission, has met twice and, for all practical purposes, it seems our work has been determined completed. However, having so stated, the fact of the matter is there is not presently a viable candidate for the position of Under Secretary for Health.

Mr. Chairman, for a variety of reasons, the individuals identified by the Commission and forwarded to the Secretary have withdrawn from consideration. Where that seems to leave us is in the unacceptable position of not having a candidate for this critical position.

Mr. Chairman, I mention this in the context of draft legislation, proposed by the Administration, which would amend Section 305(a)(2), Title 38, United States Code, repealing the requirement that the position of Under Secretary for Health be encumbered by a doctor of medicine.

It is the position of the DAV that the veterans' health care system not only needs, but deserves to have the most qualified individual possible at its helm.

Mr. Chairman, as we view the Administration's draft legislation, their proposal in no way precludes the selection of a physician for the position. Rather, and we believe correctly so, the field of potential candidates would be significantly and meaningfully broadened to include health care professionals possessing the required managerial, administrative and business skills necessary to direct a system as vast and complex as the VA health care system. In the forthcoming era of health care reform, the VA will need to possess the most dynamic, innovative and savvy management team possible in order to successfully compete for veteran patients. Limiting the pool of candidates for the Under Secretary's position is not, in our view, a wise way to proceed.

(7)

Mr. Chairman, this concludes my testimony, and I would be pleased to respond to any questions you may have.

STATEMENT OF

DENNIS CULLINAN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VA AMBULATORY CARE

WASHINGTON, D.C. OCTOBER 27, 1993

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.2 million members of the Veterans of Foreign Wars of the United States, I wish to express our appreciation for having been invited to testify here today. The VFW has long espoused the view that if VA is to properly contend with the swelling health care work load occasioned by a rapidly aging veteran population, the effective and efficient delivery of out-patient care services is absolutely critical. Thus, we are highly gratified to play a role in today's oversight hearing which is directed toward improving the timely delivery of VA's out-patient care.

As the subcommittee, is already aware, veterans made over 22 million visits to VA's more than 200 ambulatory care facilities in FY 1991 alone. Of these visits, almost 4 million were to emergency/screening clinics, 5 million were to general medicine clinics, and about 14 million were specialty clinics. Disconcertingly long waits and denied care have become the norm. In keeping with modern medical practice and in the face of pending national health care reform, which will greatly emphasize the provision of out-patient medical services, we can expect the number of VA out-patient care visits to increase many fold in up coming years. It is the VFW's assessment that the VA medical care system is totally unprepared to meet this challenge.

We would argue that this contention is amply born out by recent General Accounting Office (GAO) and VA Office of Inspector General (IG) reports which clearly depict what is known to many

in the VSO community--that veterans suffer inordinate waits and delays for out-patient care at VA facilities. Not only is this a disgrace with respect to the inconvenience and even out right denial of care this causes veterans, but given that VA will soon be forced to compete for patients against other large health care providers as provided under national health care reform, this deplorable situation threatens the very existence of the VA health care system. Simply put, given the option between a health care provider where long waits for service are the exception and politeness the rule versus one where excessive waits are a given and an inflexible bureaucratic mind set the norm, there will be absolutely no doubt that it is the former that the veteran health care consumer will select. The situation must be remedied today.

The VFW is in general agreement with the recommendations contained in the GAO report to the Secretary to restructure the ambulatory care program to improve timeliness of services. In part, these recommendations are that the under Secretary for Health should:

o establish telephone assistance networks at each facility to expedite veterans' access to medical care;

o allow veterans to schedule appointments to receive care at general medicine or primary care clinics, to the maximum extent possible;

o require all facilities to develop treatment-monitoring systems that ensure all veterans referred to specialty clinics are transferred to general medicine or primary care clinics soon after their conditions are stabilized; and,

o establish Department-wide performance goals for timely service delivery and gather system wide data that will allow facilities' performances to be measured against established goals.

While the VFW concurs with the recommendations and findings contained in the GAO Report, we would take this opportunity to also offer our own commentary on this issue which is rooted in the observation and understanding of our nationwide network of VFW Service Officers as well as our Field Representatives. These

VFW members and employees have day to day contact with the VA medical system and the veterans who are its charge. Taken as a whole, the feedback gathered from this intimate association does not represent an especially flattering picture of VA out-patient care with respect to the issue of timeliness and, in fact, point to its being dismally awry in this regard.

To begin with, even the basic task of making a clinical appointment for VA out-patient care would appear to be so arduous of a chore that it is only undertaken by those who have no alternative and those veterans who tend to be extremely persistent by nature. Getting an appointment is not just a matter of weeks, but actually months. And once a veteran has gained entrance to the system, his or her problems are still far from over. Five to six hour waits to see a doctor are not uncommon, and in those cases where medication is prescribed, the patient is then confronted with long and slow lines at the VA pharmacy. There are numerous service-connected disabled veterans--those who are clearly entitled to VA out-patient care by virtue of their personal sacrifice on behalf of the national good--who do not avail themselves of VA ambulatory care simply because they can not. I am speaking here of employed service-connected veterans who simply can not afford to take a day off from work to receive the VA health care to which they are entitled. This is disgrace and just plain wrong.

Of course, a major portion of the blame for the long waits and inordinate lines associated with VA ambulatory care can be affixed to many years of inadequate budgeting. In the words of one disgruntled veteran "OMB is killing VA." While it may be an over simplification to say that the whole problem is attributable to OMB budget cutters, there is a strong element of truth in this point of view. There is a dramatic shortage of nurse practicers as well as physicians assistants and other support personnel who could greatly reduce the burden on VA doctors and speed up the overall out-patient process. The VFW's surveys of VA facilities indicate that the inordinately long waits for ambulatory care is to a great extent attributable to the lack staff and space caused by inadequate funding. The VFW is, to say the least, greatly

disconcerted over our understanding that there is already a problem with respect to staffing levels provided in the FY 1995 VA budget. It is patently clear what is especially needed in the most critical area of out-patient care is an expansion of staff, not a reduction.

Along with inadequate staffing as a cause of the slow provision of out-patient care, another problem is the ineffective or inefficient use of available medical personnel. This has to do with inadequate space for the proper utilization of VA physicians who provide ambulatory care. For one or another incomprehensible reason, doctors at VA facilities providing out-patient care are only allocated a single examining room. Along with being totally at odds with common practice (as well as common sense) in the private sector, it means that the number of patients VA doctors can see in a day is severely and artificially limited. Once a patient enters a waiting room the doctor must wait for his or her records to be brought in, for the patient to undress, for certain basic tests to be run, and only then can the doctor attend to the patients needs. Once the visit is concluded, the doctor must, once again, wait for the patient to get dressed and exit the examining room. Then this protracted cycle repeats itself over again. Contrast this with private sector medical care where a doctor will commonly have three or four or five examining rooms so that he does not have to sit idly by waiting while records are sought and minor tests are conducted. He is free to devote himself to the physician specific needs of his patients. It is the VFW's assessment that if each VA physician were provided two examining rooms, his patient work load could be increased by 30 percent and three examining rooms would occasion at least a 50 percent improvement. Whatever the prohibition is against allowing VA to provide a sufficient number of examining rooms for its physicians, it should be eliminated immediately. The veterans health care system should at once pursue a common sense course of action allowing its physicians to devote themselves to medical practice and not sitting around cooling their heels while a VA clerk desperately searches for a misplaced medical record or a

LPN administers a common blood pressure test. One critical factor, of course, is that there be a sufficient number of medical personnel and support staff, such as nurse practitioners and physician assistants along with practical nurses and clerical support staff, to allow doctors to practice the art of medicine and not the science of bureaucratic delay.

Other factors which constitute a great detriment to VA ambulatory care is an outdated physical plant and antiquated procedures. For example, over half of the VAMCs are over 50 years old and all of them were built with the provision of in-patient care in mind. VA medical centers are now compelled to "jury rig" their physical plant so what little in-patient care they do provide is carried out as effectively as possible. Even so, the situation is far from ideal and if VA is to provide out-patient care in a proper and compassionate manner and compete with the private sector in the very near future, its health care resources must be drastically reconfigured. Just to illustrate this point, a year ago last June a study was undertaken at the Big Spring VAMC in Texas to determine how they could improve their out-patient care procedures. It was determined that from the moment a veteran set foot in the medical center for an out-patient visit to the time he received his care and was back out the door there were over 200 steps involved. The VFW cannot believe that all 200 of these steps were actually necessary, or for that matter, even advisable with respect to the sound provision of VA out-Page patient care. Granted, the Big Spring Medical Center had particular problems regarding its out-patient care services, but we maintain that this study represents problems that are endemic and system wide. Along with a change of attitude within VA, it is clear to the VFW that a substantial infusion of funding and FTEE are a requisite if VA is to correct this problem and properly care for the needs of America's veterans.

The last issue with respect to the timely and proper provision of out-patient health care by VA that the VFW will address today is one of attitude. It is the assessment of many of the VFW's members and employees who work in the field that while the actual health care available through VA is often times exemplary,

even state of the art, the conduct of those VA employees who greet the veteran at the door and then guide him into the system is something far less than even adequate. For many years VA has attended to the needs of what is essentially a "captive audience" and there is a tendency to treat veteran patients with the kind of civility that is often associated with a incensed drill sergeant or an entrenched bureaucrat. Poor manners and inflexible procedures not only make a bad situation seem worse, it actually works to the detriment of VA's effectiveness and efficiency. If for example, a veterans does not hear his name called for his appointment because he has left the waiting room for a moment to get a cup of coffee or use the lavatory, he should not be summarily dumped at the end the line and forced to endure the entire waiting cycle over again. Instead, as is the case in private practice, his file should be set aside so that he may summoned as soon as possible when he reappears. Also, if there is going to be a long delay before a veteran can be taken care of, he should be informed of this fact and told why, and not allowed to ponder his fate in silence and anger in an over crowded VAMC waiting room. When a veteran asks for information or advise, he should be dealt with in a polite manner, treating him like the much valued health care consumer that he is. The veteran should not be brusquely dismissed with the words "I don't know," or, worse yet, "no."

It is simply human nature to prefer to deal with those who treat you politely and well. We must all keep in mind that even if the VA medical system provides the very best health care in the world, and the alternative in the private sector is mediocre at best, veterans will still select the private sector health care provider if he is properly catered to there and not by VA. It is certainly a fact that while most veterans cannot truly gauge the quality of the care which they receive, they have a very good sense of how they have been treated at the door.

Mr. Chairman, once again, on behalf of the entire membership of the Veterans of Foreign Wars, I wish to thank you for including us in today's most important hearing. A germane VFW resolution is appended to this statement for review. I would be happy to respond to any questions you may have.

Resolution No. 671

STAFFING INADEQUACIES IN DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTERS

WHEREAS, the present Administration continues with its illogical personnel ceiling for the Veterans Health Service and Research Administration; and

WHEREAS, the VFW has been informed that there will be a reduction of 5,000 FTEE in FY 1994; and

WHEREAS, these personnel savings are attributed to an illusory productivity increase and a presumed reduction in patient workload which fails to take into account the increasing needs of a rapidly aging veteran population; and

WHEREAS, the Department of Veterans Affairs Veterans Health Services and Research Administration is already struggling with serious problems in the recruitment and retention of nurses, pharmacists, certain therapists and other ancillary health care professionals; and

WHEREAS, we recognize that VA contends that its personnel recruiting problems are reflective of industry shortages and we reject that position by countering that a lack of competitiveness on the part of VA is the real problem; now, therefore

BE IT RESOLVED, by the 94th National Convention of the Veterans of Foreign Wars of the United States, that we oppose this ongoing budgetary fantasizing and we urge that the imposition of productivity increases be recognized as arbitrary and inappropriate, and that personnel staffing for patient care be established based upon the mandate to treat all of those eligible under Public Law 99-272 and, further, that staffing projections recognize the fact of an increased demand to be generated by aging veterans.

Adopted by the 94th National Convention of the Veterans of Foreign Wars of the United States, held in Dallas, Texas, August 20-27, 1993

Resolution No. 671

STATEMENT OF KENNETH E. KLOTZ, JR., M.D.
ASSOCIATE CHIEF OF STAFF FOR AMBULATORY CARE
RICHARD L. ROUDEBUSH VA MEDICAL CENTER
BEFORE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
HOUSE VETERANS AFFAIRS COMMITTEE
OCTOBER 27, 1993

INTRODUCTION

This statement represents my personal views related to the issue of timeliness of outpatient care services in VHA. Concerns have been raised about a lack of timeliness of VA outpatient services including the findings of a recent audit conducted by the Office of Inspector General on outpatient waiting times at VA Medical Centers. It is essential that Department of Veterans Affairs Medical Centers deliver timely, accessible outpatient care as part of the high quality care and service provided to our veteran customers. It is also clear that timeliness of outpatient services is necessary for VHA to be competitive in a future market where veteran patients could choose between a variety of health care plans including VA and private sector providers. It is important to determine the root causes of identified problems in clinic scheduling practices and to seek practical solutions to improve the timeliness of VA outpatient services. This will help achieve a comprehensive solution to the timeliness problem.

I will describe recommendations in the following eight major areas as possible solutions to help improve the timeliness of VA outpatient care.

1. Implement a health care delivery system at all VA facilities centering around a primary care model using managed care principles.

2. Take appropriate action to assure that the level of resources devoted to outpatient care matches the demand for outpatient services.

3. Develop medical informatics capabilities to provide relevant data pertaining to outpatient waiting times. Continuous monitors using these data should be implemented to determine facility performance relative to agreed upon outcome standards. These outcome standards will be developed utilizing VA and private sector models.

4. Implement innovative systems interventions to address the numerous operational problems contributing to excessive outpatient waiting times. Input from VA and private sector health care delivery models should be employed in this effort.

5. Improve medical records systems including the implementation of an automated computerized medical record.

6. Implement an outpatient management structure that is decentralized and interdisciplinary.

7. Develop a patient centered, customer focused paradigm for health care delivery centering around high quality service to our veteran clients.

8. Create appropriate incentives for VA facilities and individual VA providers to both assure and reward high quality customer service to the patient.

RECOMMENDATIONS

A. Implement a Primary Care, Managed Care Model

Rationale: Each patient followed at VA facilities should be assigned to a primary care provider who will be responsible for coordinating the care for that patient over the full continuum of

health care services including inpatient, outpatient and long term care. This primary care provider is ideally a generalist physician such as a family practitioner or general internist working with an interdisciplinary health care team which can include nurse practitioners or physician assistants. The positive impact of this model on improving timeliness of outpatient care is listed as follows:

1. A large proportion of patients in specialty clinics have medical problems that could be competently managed by a generalist physician. Transferring these patients' care to a primary care clinic would free up clinic capacity in the specialty clinics which would lead to significant improvements in their outpatient waiting times and in the availability of prompt specialty consultation.

2. Since primary care includes continuity of care and comprehensive health care services provided by a generalist the great majority of outpatient encounters for each patient will be with their primary care provider. This should greatly improve outpatient clinic waiting times as care will be rendered by providers very familiar with the patient and thus significantly reduce the time spent in reviewing the past medical history and the hospital medical record.

3. Another role of primary care providers functioning in a managed care model is to provide a gatekeeper function controlling access to more costly specialized diagnostic tests or specialty consultations. More appropriate referral for these specialized services by primary care practitioners will improve outpatient waiting times for these diagnostic procedures and specialty clinics by reducing the volume of unnecessary referrals. Medical educational initiatives for VA staff physicians, medical housestaff, and mid-level providers should be carried out providing more training in this area. In addition further training should be carried out as needed to provide generalist physicians with the knowledge and skills to perform simple procedures capable of being carried out in a clinic setting but which are now often done by specialists. This would include sigmoidoscopies, some simple ENT procedures such as cerumen removal, etc. This would further decrease waiting times for some specialty clinics/procedures and would further the concept of "one stop shopping" maximizing the care provided by the primary care practitioner.

B. Match Demand for Outpatient Services with Appropriate Resources

Rationale: VA health care has historically been delivered predominantly through a system centered around an inpatient hospitalization with care rendered largely by subspecialty physicians. For the VA to compete with the private sector and to achieve significant improvements in the timeliness of outpatient services there will need to be shifts of resources including both space and FTEE to the outpatient setting and to expanding primary care. Currently in many VA facilities, especially tertiary care Medical Centers, staff physicians, and particularly housestaff, frequently spend the vast majority of their time devoted to inpatient care. This can result in outpatient clinics for certain disciplines such as Urology or Vascular Surgery confined to meeting only one or two half-days per week which generates an insufficient clinic capacity to meet the high demand for services for our patient population. This leads to long clinic waiting times of up to four to six months or longer for the next available clinic appointment. Subsequently well meaning physicians override their clinic schedule in an attempt to provide appropriately timed followup for sick patients with acute medical conditions which then results in substantial overbooks and long clinic waiting times for patients reporting for scheduled appointments. The following recommendations are offered in dealing with this problem.

1. Determine FTEE levels required to provide timely outpatient care and expand primary care in light of current and anticipated demand for these services.

2. Determine appropriate FTEE levels for each discipline area, such as nursing and clerical staff to assure adequate support is provided to each outpatient clinic area to enable it to provide timely outpatient services with minimum patient waiting times. This will also require changes in the job classification scale and career advancement opportunities for clinic clerical personnel as the current system fosters retention problems and rapid turnover of personnel. This creates clinic inefficiencies due to the need to constantly orient and train new employees and significantly contributes to increasing outpatient waiting times.

3. Implement strategies to recruit and retain generalist physicians and mid-level providers (nurse practitioners and physician assistants) to expand primary care services with its resulting positive impact on outpatient timeliness of care as noted above. Appropriate salary levels and benefits packages with flexibility to respond to local conditions will need to be developed as the market for these providers will become increasingly competitive. Programs designed to retrain specialist physicians to become primary care providers should also be developed.

4. Maximize space devoted to outpatient care both through new construction and by renovating existing space. The physical layout of each clinic area should be designed to maximize patient comfort and improve clinic efficiency so that patient waiting times are minimized.

C. Provide Relevant Data

Rationale: In order to provide timely outpatient care as well as cost effective care VA facilities will need ready access to relevant clinical and administrative data. These data will be essential in the monitoring of timeliness of outpatient care and the implementation of corrective action to seek continuous improvement of identified problems. Computer informatics capabilities will need to be developed to track, trend, and report these data in a manner that is meaningful and relevant to clinicians and program managers. This capability will also be crucial to document to patients, external review organizations, and purchasers of health care services that the VA can provide timely, accessible medical care. Data that will need to be examined that impact on timeliness of care include determining provider productivity, appropriate patient panel sizes for each provider, clinic capacity, waiting times, and patient satisfaction. Use of these data will enable program managers to construct appropriate clinic profiles that maximize timeliness of care. It will also be important to look at data reflecting timeliness that examines the entire outpatient experience from the time the patient drives into the facility to the time they begin the drive home. This will require looking at the waiting times associated with the laboratory, radiology, pharmacy, etc. and taking necessary action to maximize service to the patient and minimize waiting. The data obtained above will need to be compared between VA facilities and most importantly with similar waits for private health care providers in the local community. To be competitive VA health care facilities will have to meet or beat the waiting times of their local competitors.

D. Implement Innovative Systems Interventions

Rationale: To compete with private sector health care providers and to provide timely outpatient services, VA facilities must carefully examine all aspects of outpatient operations and look for innovative systems interventions to improve timeliness, quality, and service. These systems interventions will need to be made based on relevant data and by examining models both from within the VA and from the private sector. Some examples of system changes capable of improving outpatient waiting times are as follows.

1. Implement interdisciplinary primary care teams and decentralize unscheduled walk-in visits to these teams which could decrease waiting times for walk-in patients being seen by providers already familiar with their care.

2. Maximize telephone triage activity in an attempt to minimize the need for patients to physically report to the facility and with the goals of improving customer service and minimizing patient waiting.

3. Consider increased implementation of evening clinics and Saturday clinics.

4. Reduce clinic cancellations to the lowest level possible.

5. Examine strategies to provide high quality teaching of medical students and housestaff but at the same time minimizing patient waiting and improving customer service.

6. Develop an improved DHCP scheduling package that enables patients to be identified and scheduled appropriate blocks of time based on whether they are a new visit, an extended visit, or a short term followup.

7. Implement VA community based clinics to see veteran patients closer to where they live and to decrease the need for a large volume of patients from a big geographic area to all report for primary care to one central VA facility.

8. Increase the use of nurse practitioners and physician assistants in VA health care delivery.

9. Increase the integration of inpatient and outpatient care to maintain continuity of care and to improve communication and information flow between inpatient and outpatient care providers. This will improve efficiency and decrease clinic waiting times as outpatient care providers will have continuous up to date knowledge about each patient under their care.

E. Improve Medical Records Systems

Rationale: To provide efficient, timely outpatient care and to minimize patient waits, it is essential that VA facilities have high quality medical records systems. This will significantly reduce the amount of time required for clinic physicians to review the medical record and improve communication of the most relevant information to the care provider. It is equally important that the medical record is always promptly available when patients report for scheduled and walk-in visits. Listed below are some possible medical records interventions that could potentially decrease outpatient waiting times.

1. Consider increased use of a single outpatient medical record such as was recently implemented at the Indianapolis VA Medical Center. This record contains up to date information from all outpatient activity, computer printouts of reports from all pertinent diagnostic tests, and copies of recent past discharge summaries from inpatient hospitalizations. Since the vast majority of health care is rendered in the outpatient setting, use of this medical record system integrating the most relevant up to date information in a single volume of the chart is capable of significantly increasing provider efficiency and reducing patient waiting times.

2. Implement a computerized medical record system consisting of the patient's medical problem list and an integrated data base containing all relevant data pertaining to medications, laboratory and diagnostic test results, data on immunizations and other preventive health interventions, weights, vital signs, etc. Examples of this automated medical record are currently in existence at some facilities such as the Regenstrief Computerized Medical Record System at the Indianapolis VA Medical Center. These

systems also enable the implementation of computer generated reminders which can improve compliance with standards of care and potentially reduce the need for time spent in chart review for such things as a decision on the appropriate timing of various preventive health interventions on a given clinic visit.

F. Implement a Decentralized, Interdisciplinary Outpatient Management Structure

Rationale: To render timely, accessible, high quality outpatient care requires an effective outpatient management structure. Since ambulatory care is an interdisciplinary health care delivery system, it is important that its management structure be interdisciplinary and integrating what are traditionally referred to as clinical and administrative services. One example of this type of management structure is matrix management which has been successfully implemented in some VA facilities. Interdisciplinary team management is most effective if it is decentralized to the maximum extent possible including to the level of each individual clinic. However it is essential that these interdisciplinary management teams are held accountable by Medical Center top management to achieve goals and objectives related to important outcomes of care including timeliness of outpatient care and high quality service to the patient.

G. Develop a Patient Centered, Customer Focused Paradigm

Rationale: It is essential that all VA employees develop a patient centered, customer focused paradigm that drives everything that they do in the service of patients. This will be of critical importance for the VA to successfully compete with other providers of care and to obtain needed improvements in the timeliness of outpatient services. VA Central Office, the RMEC's and others have provided leadership, direction, and helpful educational programs related to customer service and TQM/CQI programs have been implemented at many VA facilities. However considerable effort is still needed to build on these achievements. Educational content related to customer service should be incorporated into the curriculum for housestaff and medical students.

H. Create Incentives

Rationale: To accomplish all of the above and improve timeliness of outpatient services, it is important that appropriate incentives be devised and implemented to help assure pertinent patient outcome improvements are achieved. One powerful incentive being considered is placing the VA health care system in competition with private sector health care providers for veteran patients. However, other incentives will need to be considered to affect behavior and foster positive change both at the national level, the facility level, and at the level of each individual employee.

CONCLUSION

Significant problems have been reported for many VA facilities related to timeliness of outpatient services which must be aggressively and proactively addressed for the VA to improve our service to the patient and effectively compete with other providers in our country's future health care system. VA Central Office and the RMEC's have already taken the lead in providing strong leadership and pertinent training including the VACO Ambulatory Care National Training Program and a recent educational conference in Tampa on primary care and managed care co-sponsored by VA Central Office and the AAMC. NAVAPAM (the National Association of VA Physician Ambulatory Care Managers), an organization that works closely with VACO and the RMEC's, is currently planning an educational program for ambulatory care physician managers on strategies to implement effective primary care, managed care programs at the facility level including development of pertinent data systems and improving service to the patient. However, much work remains to be done. I look forward to working with others as we move ahead into an exciting future.

STATEMENT OF

MR. AL GAVAZZI

Having retired after 40 years of VA service and 13 different assignments throughout the U.S., I am pleased to comment on my personal views and experiences with the ambulatory care programs within the Veterans Administration health care system.

Employs of the hospitals or clinics from Director to appointment clerks, physicians included, often forget that the patient is the most important person they have to deal with. Without the patient, in this case the veteran patient, there would be no need for a hospital, a physician, a nurse or other personnel. I have noticed lately that many employees are more interested in pay, benefits to them and size of their office, type of furniture, computers in their office, etc., then providing service to the veteran patient. Attitude of caring is not always there. The comment is made, "putting the veteran first." It sounds good, but all one has to do is visit a cafeteria or canteen around 9:00 a.m., 11:30 a.m. to 1:00 p.m. and 2:00 p.m. - 3:00 p.m., and one sees that nothing should interfere with coffee breaks or lunches. This usually comes first - the patient can wait unless its an emergency. Several recent experiences I've had, and my experiences are not unique to the system, are given below as example:

I had a 10:50 a.m. appointment at a VA clinic on September 29, 1993. I arrived at 10:00 a.m. The 24 seat clinic was overcrowded, two wheelchairs were against the wall and nine people standing against the window. I checked in at the receptionist desk and was told there would be a two hour wait. I observed during the next hour and a half that some 12 veterans walked out or had their appointments changed. After a two hour wait I was told I would not be seen until early afternoon the same day. I, too, had myself rescheduled for 8:30 a.m. on October 1st.

On my way out of the clinic area I talked to seven veterans who told me that they were very upset and they couldn't understand the

problem. As I started to leave the clinic area, I noticed several other specialty clinics just as crowded with unhappy veterans ready to leave or get rescheduled.

I reported for my October 1st appointment, arriving there at 8:00 a.m. and was seen at 10:15 a.m. Supposedly, the physician had car trouble. I might add that the physicians were most courteous and thorough once they saw the patient, as was the scheduling staff. I also found out, and know it to be a fact, that where the supervisory personnel observe the operation of the clinic things move along very smoothly. Too many chiefs sit in their offices and seldom, if ever, get out to see how the clinics are being run and how the patient is being treated. Incidentally, my next appointment is on February 1, 1994 at 10:30 a.m.

Veterans, in my view, are satisfied with the care they get once they get it. Some who are not satisfied write their Congressman or try to see the top man, as one patient told me. Then the veteran patient said "you never get beyond the secretary." The VA hospital I visited has a computerized system which is very effective, but it does not produce physicians or nurses to take care of the appointments and the patients. Staff are human. They take days off and get delayed by unexpected emergencies and there usually is no back up. This is where the chief of the clinic should get involved, and some do. Where the chief is on hand at work to see that the clinic patients are seen expeditiously or explain the cause for the delay, there is no problem. There were two clinics where I saw this being done and I heard no complaints, the lines moved along quickly and the veterans were more then satisfied with the service.

When I was working as the Director of the VA Medical Center here in Washington, DC, I visited all of the clinic areas and ward areas at least twice a day. I found this to be very effective, not only with the patients but with the staff as well. Veteran patients as well as patients in the private sector medical centers or clinics will keep their appointments if they know they will be seen within a reasonable time.

In my view, veteran patient care will improve nationally if the Director, Chief of Staff and Service Chiefs make themselves visible

throughout their facility, not only to patients and their families, but to staff as well.

There are two other issues I would like to comment on if I may. One is eligibility and the other has to do with co-payments.

Eligibility is a disaster, besides being time consuming and demeaning to the veteran, it is also costly in terms of time to fill out the application and answer all of the questions. I recommend blanket eligibility for all veterans of World War I and World War II, as was done for the Spanish American War veterans. Regardless of service connection, most World War II veterans are eligible for Medicare anyway - a tax supported health care system which most use.

Co-payments keep veterans away from VA treatment centers. Why would a veteran who lives in Frederick or Hagerstown, MD, or Winchester or Fredericksburg, VA go to the VA in Baltimore, MD, Martinsburg, WV, Washington, DC or Richmond, VA, and drive many miles when they can get the same care at the local hospital if they are covered by Medicare or health insurance. This causes low occupancy in VA medical centers and eventually empty beds. The empty beds result in criticism by the private sector and Congress.

Thank you for permitting me to give my views on the care of veteran patients.

Al Gavazzi
Retired
Former VA Medical Center Director

STATEMENT OF MR. STEPHEN A. TRODDEN
INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE
U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

HEARING ON
THE TIMELY DELIVERY OF VA OUTPATIENT CARE
AND RELATED ISSUES
OCTOBER 27, 1993

Mr. Chairman and Members of the Subcommittee, I am pleased to be here today to discuss the issue of veterans' waiting times for scheduled outpatient appointments at VA medical centers. Providing timely outpatient health care to our Nation's veterans is a primary responsibility of VA's Veterans Health Administration. During Fiscal Year 1992, scheduled outpatient care exceeded 17 million visits at VA medical centers and clinics. As you can see Mr. Chairman, this issue is significant in terms of the number of veteran contacts with VA for outpatient care. And, given President Clinton's proposal that VA compete with private sector hospitals under the National Health Care Plan, it is imperative that VA provide timely quality health care services.

The Office of Audit performed a review of waiting times for scheduled outpatient appointments at VA medical centers and published its final report in September 1993. The purpose of the audit was to determine whether veterans with scheduled outpatient appointments waited excessive lengths of time before receiving examination or treatment. We concentrated on the lengths of time veterans waited in outpatient clinics for scheduled appointments. We did not review delays in receiving physicians' initial examinations at walk-in clinics nor in scheduling initial appointments at high-demand specialty clinics.

VA policy specifies waiting times should not exceed 30 minutes. Using this guideline, we measured the period from the veterans' appointment time to the time the veteran saw a health care provider, whether that person was a nurse, technician, or a physician.

We examined clinic scheduling systems and observed waiting times for 1,259 veterans scheduled for visits at 67 clinics (comprised of 60 distinct clinics, some of which were visited twice) at 4 medical centers. In addition, we conducted interviews with responsible personnel at 39 other randomly selected medical centers to determine whether they regularly monitored their outpatient care clinics.

Our audit found that the average waiting time for the 1,259 veterans observed was about 40 minutes. This approximates the 30-minute waiting time recommended by VA policy. We found that 56 percent met the 30-minute standard, and many were seen in well under 30 minutes. However, 551 or 44 percent of the veterans waited an average of 1 hour 15 minutes. Of course, this average is influenced by veterans who experienced extremely long waiting times. We found waiting times in all types of clinics observed. However, we did not find a relationship between the types of clinics and the waiting times experienced in the clinics.

At the four VA medical centers visited, we found five clinic practices which contributed to excessive waiting times for veterans with outpatient appointments, as noted below. We identified these inappropriate practices by first determining clinics experiencing excessive waits, and then observing each clinic to determine the underlying cause or causes of the excessive waiting times:

1. Excessively overbooking appointments.
2. Block scheduling of appointments.
3. Allotting insufficient treatment time per appointment.
4. Not adhering to established appointment schedules.
5. Delaying the start of clinics because of the absence of physicians.

In my opinion, had responsible medical center personnel monitored clinic operations, these practices, as well as other practices contributing to excessive waiting times, could have been identified and corrective action taken. None of the four medical centers reviewed had established such a process. Since outpatient waiting times were not monitored by these medical centers, responsible officials were not aware of the full extent of the problem. A description of these inappropriate practices follows.

Excessively Overbooking Appointments. To compensate for patients who fail to report for clinic appointments, VA policy allows scheduling personnel to overbook clinics. We consider this to be an acceptable practice. To accomplish this, each clinic is required to establish a clinic profile which specifies the total number of patients who can be treated each day -- including overbooks. Clinic profiles should be established using historic workload data including patient cancellation and no-show rates, and the average treatment time per patient. In addition, affiliated medical centers must consider other issues such as the number of residents who will rotate through the facility each semester and the amount of time teaching takes away from patient care.

Our review found clinic profiles were often not current or were not followed. In fact, 40 clinics had profiles that had not been updated within one year or had no profile. Some profiles had not been updated since 1985. Consequently, excessive waits resulted because the profiles didn't accurately reflect the availability of physicians and other health care providers. Also, clinics were overbooked beyond their capacity. For example:

- The profile for one clinic showed there should be five health care providers available in the clinic. However, the profile had not been updated to reflect current available staffing. In fact, only three health care providers were usually available.

Block Scheduling Appointments. All four medical centers reviewed used block scheduling. Block scheduling is the practice of scheduling large numbers of patients at the same time that are in excess of those that can be seen by health care providers and is specifically prohibited by VA policy. Instead, the appointment schedule should be subdivided into appropriate time

intervals throughout the total workday. By having patients all show up at the same time, some patients have to wait an inordinate amount of time before being seen. For example:

- We observed a clinic where, at 8:30 A.M., 25 patients were block scheduled for a rheumatology clinic staffed by 6 physicians. Because these patients didn't have individual appointment times, this practice resulted in an average patient waiting time of 1 hour 37 minutes. Patient waits ranged from 35 minutes to 3 hours 47 minutes.

We also determined that clinics were block scheduled for the convenience of the medical center staff. Patients were scheduled into the earliest appointment slots so employees could get out of the clinic quicker if the patient workload was light that day.

Another disadvantage of block scheduling at the beginning of a clinic is apparent when physicians arrive late for the start of the clinic, as we will discuss later. If some or all of the physicians are late, the entire clinic gets backed up and even the earliest patients to arrive experience delays.

Allotting Insufficient Treatment Time Per Appointment. VA policy specifies that appointment time intervals be based on an analysis of the times required for patients to complete their visits. However, at all four medical centers reviewed, clinic-scheduling personnel did not provide enough time for each appointment to allow the patients to receive all necessary treatment. At one clinic, because insufficient treatment time was allotted per patient, the average waiting time was 1 hour 24 minutes. We determined that, on average, it took 51 minutes for a patient to be examined, but patients were scheduled at 15-minute intervals. Had a system been implemented to monitor clinic operations, the clinic profile could have been adjusted to change the length of time allowed for each appointment.

Not Adhering to Established Appointment Schedules. Patients often experienced excessive waits because clinic staff did not follow appointment schedules. Also, clinics frequently treated walk-in patients ahead of scheduled patients, although we were told this should only happen in cases of

medical necessity. We compared clinic appointment schedules with the order in which physicians saw patients. Instead of seeing patients in the same order as their appointment times, physicians saw patients on a first-come, first-served basis. This occurred at 3 of the 4 medical centers; staff at 20 clinics visited did not adhere to established schedules, which resulted in unnecessary waits. For example:

- One patient with a 1:00 P.M. appointment in a surgery clinic was not called for treatment until 2:44 P.M. During this time, 16 veterans with later appointments were seen before him.

When clinics do not adhere to appointment schedules, but instead treat patients on a first-come, first-served basis, patients perceive all clinics are operated this way. As a result, patients arrive hours early for their appointments causing congestion in clinics that are often physically small.

Delaying the Start of Clinics Because of the Absence of Physicians. To determine whether physicians' late arrivals at clinics affected patient waiting times, we observed the start of each clinic and recorded physicians' arrival times. Our observations showed that 22 clinics reviewed were delayed by an average of 37 minutes because of the late arrival of physicians. In some cases, there were legitimate reasons why physicians arrived late for these clinics, e.g., emergency clinical procedures and hospital rounds. On the other hand, some physicians took excessive lunch breaks and some scheduled physicians failed to show up at all. The problem is compounded when patients are block scheduled in the earliest appointment slots and some or all of the providers arrive late. We found this practice at three of the four medical centers reviewed. As a worst case example:

- An afternoon session of an orthopedic clinic was to begin at 12:30 P.M. However, the three physicians staffing the clinic were late returning from lunch by an average of 50 minutes. Seventeen of the 34 patients examined that afternoon waited more than 30 minutes beyond their scheduled appointment time before being treated. One patient waited 2 hours 30 minutes for his scheduled examination.

It is also very important to recognize that many of the physicians we observed arrived early for their clinics and stayed late. Some providers even worked straight through the day without a lunch break. The VA has many hard working, dedicated physicians.

It should also be noted that the Office of Inspector General, through its Hotline and Special Inquires Division, receives allegations and complaints from veterans. Some of these complaints have focused on extended waiting times in clinics. These complaints illustrate the results of the breakdown of clinic management as shown by the audit report.

In conclusion, we believe that waiting times could be decreased if VA required medical centers to periodically monitor clinic waiting times, identify the practices causing delays, and then take corrective action. However, in our opinion, monitoring will only be effective if requirements are enforced by responsible medical center officials. Communication between health care providers and administrative personnel is imperative to develop cross-departmental quality assurance monitors, and address problems with ancillary services and resource allocation.

To reduce waiting times and provide better service to veterans, we made four recommendations to the Under Secretary for Health to require all medical centers to:

1. Regularly monitor outpatient waiting times.

2. Analyze data collected from the monitor on outpatient waiting times to identify clinics experiencing waiting times, determine the clinic practice(s) causing unnecessary delays, and take appropriate corrective action.

3. Regularly update clinic profiles.

4. Not schedule patient appointments in excess of levels recommended by clinic profiles unless required by medical necessity.

I would like to point out that many of the medical centers surveyed were very receptive to our reviews and indicated that they had or will implement controls to identify and correct problems in clinics experiencing delays. We were also informed that a software package was being developed to monitor waiting times through the Decentralized Hospital Computer Program (DHCP).

The Under Secretary agreed with our recommendations and provided acceptable implementation plans. The Under Secretary will require medical centers to perform outpatient clinic waiting time studies on a quarterly basis. The results of these time studies are to be analyzed to identify clinics with excessive waiting times and potential causes for delays are to be determined. Medical center directors are to be held responsible for ensuring appropriate action is taken to correct any problems identified. The directions given by the Under Secretary, in my opinion will, when implemented, go a long way toward identifying and correcting the factors which contribute to the problem.

As a result of our review, other important related points have come to our attention. First, the 30-minute waiting time standard may not be appropriate for all clinics. Second, the length of time it takes to complete an episode of care is also a factor to consider in achieving patient satisfaction with VA outpatient care. Effectively addressing the audit findings as well as these issues could help the VA improve timely delivery of outpatient care and become competitive under the National Health Care Plan.

STATEMENT OF
ELWOOD J. HEADLEY, M.D.
ACTING DEPUTY UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
BEFORE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
HOUSE COMMITTEE ON VETERANS' AFFAIRS

OCTOBER 27, 1993

Mr. Chairman,

I appreciate the opportunity to discuss VA's Outpatient Treatment Programs.

VA provides a wide range of services to veterans through its Ambulatory Care Programs. Outpatient services are provided at 170 medical center outpatient clinics, 53 satellite clinics, 44 community based clinics, 81 outreach clinics, 7 independent clinics and 6 mobile clinics. VA also provides outpatient services through its home care, homeless, and counseling programs. Where VA facilities are not accessible for veterans with a high priority claim to service, VA contracts for care in the local community. In Fiscal Year 1993 veterans made 24.1 million outpatient visits and we anticipate 24.6 million visits in FY 1994.

Mr. Chairman, the General Accounting Office and the VA Inspector General have recently recommended improvements to VA's Outpatient Programs. The VHA has concurred generally with these recommendations and is taking corrective actions. While these audits found deficiencies in management of some outpatient programs, they also identified innovative approaches that several VA medical centers are taking to improve service to veterans.

Mr. Chairman, our long-term approach to improving our outpatient programs will be to implement the President's Health Care Reform program through a managed care/primary care strategy within the VA. Currently, we are making progress toward implementing primary care concepts. In the immediate future, the Under Secretary will issue guidance to all VA facilities urging progress toward implementing primary care and improving the timeliness of outpatient services. We are also issuing directives which will clarify requirements to monitor the timeliness of service provided in each VA scheduled clinic.

Medicine is difficult to schedule. Physicians feel that it is preferable to spend whatever time is necessary with a patient, even if it means keeping others waiting. There is no ideal time slot that can conveniently accommodate all patients. An elderly veteran with multi-organ disease and no previous medical records can require an hour of a caregiver's time, even though clinics may routinely allow only 15 or 20 minutes per slot. Emergencies are unpredictable and take priority over scheduled appointments. Also, it is impossible to always predict walk-in demand and have staff available. Some delays are unavoidable.

VA has some particular problems which compound the situation. Demand for VA care generally exceeds our ability to supply it and many veterans have no alternative source of care. VA clinics stretch their resources to care for as many patients as possible but are not able to care for all veterans who apply for services.

Nevertheless, we believe that improvements are possible and efforts are under way to improve our outpatient programs. The VHA is developing a plan to implement a managed care strategy that will place emphasis on primary care. A managed care/primary care strategy will be crucial to VA's success after National Health Reform. VA care will have to be comprehensive, coordinated, cost effective and delivered in a timely manner. Full implementation of this strategy will require implementation of the President's plan for Health Care Reform. We are requesting medical centers to increase efforts to implement primary care as a means of improving timeliness of outpatient services. VA hospitals have already developed outpatient managed-care systems in a variety of settings. The GAO recommendations to establish telephone assistance networks; to provide patient-scheduled appointments; to transfer specialty patients to primary care; and to manage the care of patients in all settings have been implemented by many VA medical centers.

Other initiatives underway to improve our ability to provide outpatient services include:

*Mobile labs are being established in Ambulatory Care areas to expedite the most basic tests needed in Outpatient Departments.

*The "Pharmacy without Walls" is being tried in many medical centers. A pharmacist in the outpatient area enters prescriptions on the computer system and counsels patients regarding their drug therapy while the prescription is being filled in the Pharmacy.

*The Pharmacy Service is pilot testing a highly automated and responsive system to provide outpatient medications. This initiative called "Computerized Mail Out Pharmacy" (CMOP) will reduce waiting times for medications and will improve our ability to monitor each patients' drug therapy.

Mr. Chairman, our future depends on VA's ability to provide high quality and responsive outpatient services. The recent GAO and IG audits found problems in our program that require immediate attention. Passage of the President's Health Reform proposal and implementation of the managed care/primary care strategy in the VA is needed to allow VA to achieve the maximum use and benefits from its outpatient programs.

* * *

QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN

SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
VA AMBULATORY CARE TIMELINESS AND RELATED ISSUES
OCTOBER 27, 1993

QUESTIONS FOR MR. DAVID P. BAINE
DIRECTOR
FEDERAL HEALTH CARE DELIVERY ISSUES
HUMAN RESOURCES DIVISION

1. **Identify the ambulatory services for which VA should establish department-wide delivery performance goals. How frequently should each facility's actual performance be compared to these goals?**

VA should establish Department-wide performance goals in the emergency/screening clinics to measure waiting times between (1) triage and a physician's initial examination, and (2) the initial examination and discharge; VA now has one existing goal to measure time between a veterans' arrival and triage. Goals should also be established for appointment availability in general medicine and specialty clinics. Facilities should monitor waiting times quarterly, or as often as the facility director deems necessary.

2. **Why does GAO believe significant improvements in VA outpatient health care delivery can be achieved without additional resources?**

GAO believes that VA can significantly improve its outpatient care, by restructuring its delivery processes to better use existing resources. For example, individual veterans frequently receive routine medical treatment from a number of specialists. Primary care physicians could provide a comparable level of care and thereby reduce waiting times for veterans in need of specialty care. Because primary care physicians are less costly than specialists, VA would realize a savings which could be used to finance this restructuring and offset the need for additional resources.

Other operational efficiencies, such as telephone assistance networks, would also generate cost savings because lower cost staff, generally non-physicians, could often meet veterans' needs, such as refilling prescriptions or answering questions about prescription or general eligibility requirements. These savings could then be used to finance telephone assistance networks or other restructuring activities.

3. **What has VA done to determine why veterans do not keep scheduled outpatient appointments and how has VA used this information to reduce the number of missed appointments?**

VA does not require facilities to routinely determine why veterans miss scheduled appointments. While most facilities GAO surveyed (60 percent) automatically rescheduled missed appointments, some facilities independently tried to determine why veterans failed to keep appointments. For example, at one facility, veterans' forgetfulness was the most common reason (29%) that scheduled appointments were missed. Other reasons included veterans being unaware that appointments were scheduled, poor weather conditions, veterans changing residences, or conditions no longer requiring treatment (6-9% response in each category.) Another facility found that shortcomings in its scheduling process resulted in veterans not receiving notice of scheduled appointments.

Some VA facilities have used this information to develop appointment reminder systems, whereby notices are sent to patients about 10 days before scheduled appointments. VA commented that they also plan to educate veterans about canceling appointments.

4. When GAO examined VA outpatient care delivery, what was most surprising?

GAO found it surprising that VA facilities required veterans to walk-in and apply for an unscheduled clinic visit rather than providing them an opportunity to contact their provider for such routine services as medical advice relating to prescribed treatments or prescription refills.

Also, it was surprising that VA facilities scheduled appointments without consulting the veterans and then mailed notices to veterans without personally contacting them. This approach denies veterans a chance to select a convenient day and time when they can use the appointment.

5. Identify the practices not now used systemwide in VA which private sector officials suggested VA adopt to reduce waits for ambulatory care.

GAO identified several practices used in the private sector that could reduce waits for VA care, if adopted. These included appointment scheduling systems, telephone assistance networks, primary care networks, and performance monitoring systems.

STATEMENT OF KENNETH E. KLOTZ, JR., M.D.
ASSOCIATE CHIEF OF STAFF FOR AMBULATORY CARE
RICHARD L. ROUDEBUSH VA MEDICAL CENTER
INDIANAPOLIS, INDIANA

RESPONSE TO QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
VA AMBULATORY CARE TIMELINESS AND RELATED ISSUES

OCTOBER 27, 1993

INTRODUCTION

This document represents my personal views in response to questions submitted by the Subcommittee on Oversight and Investigations, House Veterans Affairs Committee in followup to my written and verbal testimony provided on October 27, 1993 regarding timeliness of outpatient care services in VHA.

RESPONSE TO QUESTIONS

1. Identify the changes made and planned at the Roudebush VA Medical Center to improve VA ambulatory care delivery and provide a cost estimate for each. What other improvements, if any, are needed for the Roudebush VA Medical Center to be fully competitive with the best primary care available in the community? Please provide a cost estimate for each improvement identified.

CHANGES AND IMPROVEMENTS MADE AND PLANNED AT THE ROUDEBUSH VAMC

1. Implement a Primary Care, Managed Care Model: Currently approximately 50% of our active outpatients have been assigned to a primary care physician (general internist) in our general medicine clinic. Our goal is to assign every active outpatient a primary care general internal medicine physician who will then manage the patients care over time seeking to provide care at the most cost effective level. We are currently examining data related to clinic workload, provider productivity and panel sizes, utilization review information together with looking at local private sector models. This information will be used to determine current general medicine clinic capacity and what additional resources (space and FTEE) might be needed to assign 100% of our active outpatients to a primary care physician. The assignment of all outpatients to a primary care provider will enable many of these patients to be discharged from specialty clinics thus improving specialty clinic waiting time.

We also will be examining private sector, particularly HMO, models for ideas to implement the delivery of managed care to our VA primary care patient population. We will be working with fellow Department of Medicine faculty members at our University affiliate in this effort as they currently have a private sector HMO initiative, Indiana University Health Care. We will collaborate with them to look at strategies for implementation at our VA Medical Center to assure appropriate, cost effective utilization of resources including the use of expensive specialty diagnostic and therapeutic services while maintaining high quality care.

We are also working with our University affiliate to determine what office/outpatient procedures that historically have been done by specialists at academic medical centers could now be taught to and performed by general internal medicine physicians in a primary care setting. This would reduce the need to refer the patient for costly specialty care for certain procedures and at the same time reduce the waiting time for these same procedures. It would also help foster the concept of "one stop shopping" where as much of a patient's care as possible is carried out in a primary care clinic.

2. Implement Strategies to Recruit and Retain Generalist Physicians and Mid-Level Providers: There is considerable local effort within our Division of General Internal Medicine both at the VA Medical Center and at our University affiliate to examine strategies to recruit and retain generalist physicians in what will be an increasingly competitive market for these providers. Several University task groups with VA and University based general internal medicine faculty are currently looking at this issue. The Division of General Internal Medicine also had a two day retreat in January, 1994 in which this topic was discussed in depth. We feel strongly at the local level that the current VA and University salary structure for general internists and other generalist physicians is not competitive with the private sector, particularly at the entry level, and that this will severely impact on recruitment and retention of these providers. Local and national attention will need to be given to address this issue including reexamination of the special pay package as it applies to VA primary care physicians. However, in addition to looking at the compensation package we are also looking at several other areas related to recruitment and retention of generalist physicians that pertain to job satisfaction, working conditions, academic promotion, professional development, etc.

With the increasing use of nurse practitioners in our VA Medical Center's primary care teams we are working to develop an innovative curriculum for these providers to enhance their function as physician extenders in the primary care setting and as a recruitment and retention tool.

We are also involved in several local primary care educational initiatives that we are hopeful will increase interest in primary care and result in more primary care physicians entering the VA, University, and private sector workforce. These educational venues involve primary care ambulatory medicine rotations for junior medical students and medicine housestaff both at our VA Medical Center and University affiliate.

3. Obtain Pertinent Data: In June, 1993 our VA Medical Center formed a Primary Care, Managed Care Task Force to oversee our expansion of primary care services, implementation of managed care and to create a health care delivery system that provides high quality care and service to our patients in a cost effective manner. Two of the subcommittees of this Task Force, a Data Subcommittee and an Evaluative Subcommittee, look at quality of care, quality of service, patient satisfaction, and utilization review data and then use these data to make decisions to improve the quality and timeliness of our outpatient services. We are still developing these data sets but have made considerable progress in the last six months. Unfortunately much of the data has had to be manually collected but we are working with our medical informatics section to automate the collection and analysis of these data as soon as feasible. The data we are planning to look at fall in the following areas:

a. Determining productivity and appropriate panel sizes for each primary care provider. We are at present looking at the data for our current system. Then we will use data from private sector HMO models for benchmarking purposes to consider what adjustments or improvements may be necessary. In January, 1994 we had a meeting with the physician director of Indiana University Health Care, the HMO of our University affiliate, to examine benchmarking data related to local and national HMO standards of performance with regard to provider productivity, panel sizes and timeliness criteria. We will use these data with appropriate adjustments due to our teaching mission to examine the current performance at our VA Medical Center and make changes as indicated.

b. Determining current clinic capacity of our general medicine clinic considering detailed and sophisticated data sets relating to scheduling rates, utilization rates, etc. This will enable us to

maximize our clinic efficiency using existing resources and to help us determine what additional resources we will need to transfer the care of all active outpatients to our general medicine clinic.

c. Examining data relating to waiting times to the next available appointment and waiting times during a clinic session to determine strategies to decrease outpatient waiting times and improve timeliness of service. These data will attempt to look at end to end waiting times from the time the patient pulls into the parking lot until the time they leave the facility and examine individual factors contributing to waiting times including those associated with radiology, laboratory, pharmacy, etc. We are currently actively pursuing implementation of a bar coding system to enable us to accurately determine information pertaining to the length of patient waiting times in clinic.

d. Collecting data related to patient satisfaction.

e. Examining current clinic profiles and outpatient scheduling strategies in light of the above data and making any needed changes to assure improved timeliness of care and service.

f. Using the above data for our VA Medical Center in conjunction with benchmarking data from private sector models will enable us to make appropriate changes to improve our health care delivery systems and improve our timeliness of outpatient services.

4. Implement Innovative Systems Interventions:

a. We have implemented interdisciplinary primary care teams and are decentralizing unscheduled walk-in visits to these teams which will decrease waiting times for these walk-in patients as they will be seen by providers already familiar with their care.

b. We are implementing an improved telephone triage system where patient phone calls are decentralized to the primary care team and triaged by registered nurses and nurse practitioners from that team. We have developed an improved computer generated encounter form to record pertinent information related to the telephone interaction and for data collection and tracking purposes.

c. We are considering implementation of evening and Saturday clinics but this initiative is only in the very early planning stages.

d. Clinic cancellations are currently being examined by an interdisciplinary committee in an attempt to reduce them to the lowest level possible.

e. As part of our restructuring of clinic profiles we are looking at possible local development of a change in our clinic scheduling system to allow the identification and scheduling of patients at appropriate blocks of time based on whether they are a new visit, extended visit, or short term followup visit.

f. Our University affiliate has a number of community based clinics that service the patients cared for by our local county hospital and also for those patients seen by their University HMO. We are working with them to plan implementation of VA community based clinics to care for our veteran population consistent with National Health Care Reform.

g. We have hired four additional nurse practitioners and plan to assign one to each of our four primary care teams to enable us to more effectively see walk-in patients by each team, help improve continuity of care, assist in improved care rendered through telephone triage and improve patient education.

h. In the very early planning stages are initiatives to improve the integration and continuity of care between inpatient and

outpatient services at our VA Medical Center. We have had outpatient primary care FIRMS for some time. However, implementation of inpatient/outpatient FIRMS has been hampered by the fact that our medicine residents rotate between the VA and two other hospitals on campus which would require a major overhaul of our entire campus wide health care delivery structure. Despite this there is interest in exploring the possible implementation of this FIRM structure by our VA Medical Center and the University and discussion of this issue is currently in progress.

5. Improved Medical Records Systems:

a. Our VA Medical Center's medical informatics department has developed and implemented a modified version of the Regenstrief computerized medical record system written in the MUMPS language and contained within DHCP. This medical record system contains a list of the patient's diagnoses together with an integrated data base containing all relevant data pertaining to medications, laboratory and diagnostic test results, data on immunizations and other preventive health interventions, weights, vital signs, etc. It also contains a computer generated reminder function to prompt physicians at the time of the patient visit to perform indicated interventions to increase compliance with standards of care particularly those pertaining to preventive health care. A HOST proposal on this initiative was recently submitted to VA Central Office by our facility.

b. In June, 1993 we implemented a separate outpatient functional record that contains up to date information from all outpatient activity, computer printouts of reports from all pertinent diagnostic tests, and copies of recent past discharge summaries from inpatient hospitalizations. This information is all contained in a single volume of the patient's hospital chart in a highly integrated and well organized fashion. Use of this medical record system is expected to significantly improve provider efficiency, improve medical record availability, and potentially reduce patient waiting times.

6. Cost Estimates: The Data Subcommittee of our Primary Care, Managed Care Task Force is beginning the process of developing methods to look at the costs related to resources required to provide primary care and managed care for our patient population and the costs of care delivery. This effort is severely hampered by the lack of a patient based cost accounting system in the VA. We are working with our University affiliate and benchmarking with their University HMO and other local community HMO's to develop methodology to look at the optimum resources required to care for a given panel of patients adjusted for the need to fulfill our teaching mission for housestaff, medical students, and the associated health disciplines. We are also working collaboratively with our University affiliate to develop clinical practice guidelines for various common medical problems that will enable us to potentially reduce the cost of care for certain conditions-i.e. minimizing the use of MRI of the spine for low back pain, etc. Development of accurate cost data pertaining to needed resources and costs associated with health care delivery will require a substantial effort that will require at least several months before initial data will become available.

2. Your written testimony could serve as a checklist for the actions needed to improve VA ambulatory care systemwide. Please prioritize these actions.

PRIORITY OF ACTIONS: The following actions are prioritized from highest to lowest

1. Implement a Primary Care, Managed Care Model

2. Implement Strategies to Recruit and Retain Generalist Physicians and Mid-Level Providers

3. Obtain Pertinent Data and Implement Innovative Systems Interventions

4. Improve Medical Record Systems Including Implementation of a Computerized Medical Record System

3. What common obstacles do most VA Associate Chiefs of Staff for Ambulatory Care face attempting to improve VA ambulatory care delivery and reduce veteran waits for ambulatory care?

a. Though I have focused on the need to expand primary care services within the VA, to provide comprehensive health care services requires a strong medical and surgical subspecialty component. Transferring care of patients from specialty clinics to primary care clinics will help improve outpatient waiting times for the specialty clinics. However, in my opinion this will not be enough. There will need to be a commitment by University Departmental Chairmen and Division Chiefs to devote more resources to health care delivery in the ambulatory care setting.

b. The ACOS for Ambulatory Care has overall administrative authority for all outpatient care and activities within the VA facility. However, this substantial responsibility is not coupled with line authority over any of the clinical Bed Services or clinical and administrative support services. This problem can be overcome as it has at our VA Medical Center in Indianapolis with strong top management support and through the establishment of an effective interdisciplinary matrix management structure. In VA Medical Centers where this is not the case there may be an inability of the ACOS to effectively deal with difficult or controversial issues that cut across the various departmental or service lines.

c. We need to establish appropriate incentives to help assure pertinent patient outcome improvements are achieved. These incentives can be used to affect behavior and promote positive change.

d. There needs to be increased local flexibility regarding various personnel issues so that we can assure that we maintain a highly competent and motivated work force. We must have competitive salary structures based on what it takes to recruit and retain quality employees in various positions in competition with other community health care providers. This will be especially important as the market for primary care physicians and mid-level providers becomes increasingly competitive.

e. VACO space criteria need to be less prescriptive with broader degrees of freedom to develop innovative designs at the local level within a given budget.

f. Improved computer software packages need to be developed to better provide relevant data needed by local clinicians and program managers to obtain improved information pertaining to quality, service, workload, productivity, etc. Also except for a few facilities, such as Indianapolis, there is lack of a computer data base containing a list of the patients diagnoses.

g. VA facilities are subject to an excessive number of external reviews by various organizations and government agencies. Many of these reviews are redundant and require considerable local time and resources to prepare for and participate in. The number and type of such external reviews should be reduced to the same level as private sector hospitals so that the VA is on a level playing field with our private sector counterparts.

h. Balancing the VA's educational mission to teach housestaff, medical students, and trainees from associated health disciplines with the need to provide timely service to veteran patients and compete with the private sector in such areas as cost and provider

productivity will require innovative adjustments in our health care delivery system.

4. Do VA Medical Centers require more or less autonomy to improve ambulatory care programs and delivery? Please explain your response.

From all that I have said above, I feel strongly that there should be more autonomy and flexibility at the local level to delivery health care services in competition with the other providers in the community. This will enable each individual VA Medical Center to develop innovative facility plans based on the local health care market and then rapidly and proactively respond to changes in that environment.

QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

VA AMBULATORY CARE TIMELINESS AND RELATED ISSUES

OCTOBER 27, 1993

Question 1: According to a recent article in the American Journal of Medical Quality, "The VA could do the nation a great service by exerting its influence to encourage an immediate enhancement of primary care residencies they support."

Will VA, "encourage an immediate enhancement of primary care residencies they support?" How and when?

In terms of timely outpatient care delivery, is VA's medical education mission better serving the needs of the nation's veterans or the needs of the nation's medical schools today?

Answer: Several years ago the Veterans Health Administration (VHA) began to focus on increasing the number of physician resident positions in primary care areas (internal medicine, family practice) and to decrease emphasis on subspecialties such as cardiovascular diseases, rheumatology, and nephrology.

Recently VHA announced the Primary Care Education (PRIME) initiative, a creative pilot program for the interdisciplinary training of medical residents and associated health students to meet the challenges of a managed care environment. In FY 1994, VA began supporting trainee salary for both staff and students to prepare for clinical roles in new health care delivery models. Several hundred new resident positions will be funded to increase primary care education in VA.

We believe that VA's medical education mission through its partnership with the nation's medical schools has served the needs of the nation's veterans very well. These long established partnerships, with benefits to both parties, focus their efforts on providing quality patient care, education and research. In this process, the American veteran has received the same high quality of medical services as is available in the great teaching hospitals. As VA missions change under Health Care Reform, the funding of residents and the graduate medical education relationship to affiliated academic medical centers will be changed to reflect the primary care emphasis of VA.

HONORABLE LANE EVANS

Question 2: Transferring veterans into general medicine and primary care clinics from unnecessary specialty clinics and monitoring veterans in specialty clinics so that they may be transferred to general medicine or primary care clinics as their conditions stabilize are two VA goals.

Provide the date VA expects to accomplish these goals systemwide.

If VA has the staff, equipment and facilities needed to accomplish these goals today, why haven't these goals been accomplished already? If VA doesn't have the staff, equipment and facilities needed to accomplish these goals today, what additional resources are needed to accomplish these goals systemwide?

Answer: Information Letter 10-93-031, Primary Care as a VHA Priority, dated October 28, 1993, which is attached, encouraged the field to move forward with primary care initiatives. The letter suggested a review of specialty clinics to identify patients who could be more appropriately treated in primary care clinics. This movement of patients into primary care clinics will allow more timely consultation and treatment of patients referred from specialty care.

A National Training Program on the Implementation of Primary Care was initiated in FY 1993. Region 3 received training last year (May 1993) and Regions 1, 2 and 4 will receive training during April/May 1994. These programs outline models of primary care, provide an interdisciplinary framework for teams to function effectively and also allow the sharing of ideas.

The resources needs to accomplish our goals are being determined at both the local and national level. Primary care has already been implemented in some medical centers. Some facilities accomplished this through the use of existing resources while others obtained funds from other sources, e.g., Western Region has provided start-up funds to some facilities.

Enactment of the President's health reform proposal will provide VA with the tools and funding sources to fully implement primary care in a managed-care environment.

Question 3: Waiting time studies conducted regularly by Sacramento VA outpatient clinic managers show patients, on average, wait about three hours to be seen by a physician, according to the Inspector General; waiting time studies alone will not improve outpatient care delivery timeliness.

Identify the changes needed systemwide for VA ambulatory care delivery to be veteran-oriented and community-competitive and estimate the cost of each change reported.

Answer: A directive (VHA Directive 10-94-022) to implement TLCP (Telephone Liaison Care Program) was issued on March 18, 1994 (copy attached). This directive mandates the use of the telephone and other actions that will help reduce excessive waiting times. Efforts will be focused on reducing the number of "walk-ins," i.e., patients who walk into clinics without a scheduled appointment and "no-shows," i.e., patients who have scheduled appointments and fail to present themselves at the clinic.

Information Letter 10-93-031, attached, instructs facilities to review current patient enrollment in specialty clinics, i.e., Cardiology, Pulmonary, Neurology, etc., to determine those patients whose condition can be treated more appropriately in a primary care setting and encourages movement toward primary care.

VA agrees that merely studying patient waiting times will not improve services, but it will tell us where severe problems exist. Therefore, automated computer tracking has been developed which will enable facilities to monitor their waiting times in the outpatient clinics.

Enactment of the President's proposed Health Security Act will provide VA with the tools required to be a competitive health care provider for veterans and dependents. Specific implementation plans are under development within VA but have not been approved by the Secretary at this time.

Question 4A: Provide the date when ambulatory care telephone assistance will be operational at each VA facility.

Answer: We anticipate that all facilities will have some aspect of the telephone visit program operational by the end of Fiscal Year 1994.

Question 4B: Provide the date when veterans will be able to schedule and change outpatient care appointments by phone at all VA facilities.

Answer: VHA Directive 10-94-022 requires all facilities to establish Telephone Liaison Care Programs. We expect substantial compliance with this directive during FY 1994. This program will assist veterans in resolving a range of concerns about their care including scheduling problems.

Question 5: Systemwide how can VA facilities more effectively remind veterans of scheduled appointments to reduce the number of missed appointments? When will this be done at all VA facilities?

Answer: One of the most efficient methods of notifying and/or reminding patients of appointments is through telephone notification. Some VA facilities have a "teleminder" telephone system in place to notify patients; however, the availability of resources is a consideration for each facility considering the purchase of this equipment.

We conducted an informal survey of 78 facilities in October 1993 to determine how facilities notify patients of scheduled appointments.

- *58 facilities or 74 percent indicated that they were utilizing the automated appointment letter;
- *2 facilities or 3 percent were using telephone notification exclusively;
- *17 facilities or 22 percent used both letter and telephone notifications;
- *1 facility or 1 percent indicated that no notification is provided other than appointment date and time on the back of the patients' data cards at the time of departure from clinic unless a clinic is canceled; then, letter or telephone call is used to notify the patient. It is important to note that this facility indicated that they had a very low "no-show" rate of 5 percent.

A total of 99 percent of the facilities surveyed indicated that patients were receiving formal notification/reminders for their scheduled appointments.

Question 6: The San Juan VA Medical Center reportedly achieved significant improvements in ambulatory care management and delivery after receiving management assistance provided by VA's Health Care Management Continuing Education Center (HCMCEC).

Describe the assistance provided by HCMCEC, the resulting improvements achieved by the San Juan VAMC and explain why the assistance provided by HCMCEC was so effective. How many other VA facilities will receive this assistance from HCMCEC this fiscal year?

Answer: Three San Juan VA Medical Center employees attended the Ambulatory Care National Training Program provided and conducted by the St. Louis Continuing Education Center through the Office of the Associate Chief Medical Director for Academic Affairs. This training was held in Tampa, FL, May 25-28, 1993.

The target audience for this National Training Program included three member teams (physicians, nurses, and social workers) from selected VAMCs. The program included information about nine models of primary care delivery currently in use in VA, quality management, and information needs for the delivery of outpatient care. A large portion of the program was devoted to fostering team identity and functioning among physicians, nurses, and social workers attending the program. As a result of this program, many of the skills that were gained through a team building approach have improved overall ambulatory care management and delivery at San Juan.

Twenty-eight first-line supervisors and service chiefs at the San Juan VA Medical Center were also involved in a separate training program in management skills. This management skills training program was conducted by HCMCEC. The Office of Academic Affairs is studying the function of future management skills training for VAMC managers in the context of national health care reform.

Question 7: Computers were supposed to solve scheduling problems in VA. Why haven't they?

Answer: We are encouraging the field to take steps to reduce scheduling problems. The field has been directed to review current patient enrollment in speciality clinics to determine those patients whose condition can be treated more appropriately in a primary care setting (See VHA Directive 10-94-022, attached).

Question 8: Why aren't the innovative actions taken by a few VA facilities to improve outpatient care delivery and reduce patient waiting times being used in all VA facilities?

Answer: VHA has developed a National Training Program entitled: "Primary Care: A Foundation of Managed Care in Health Care Reform." Part of this program entails poster sessions during which medical centers share information on new or novel ways to implement primary care. These sessions have included methods to improve primary care delivery and use of telephone triage to reduce waiting times and more effectively use clinic times at VA facilities.

As discussed in response to Question 3, VHA Directive 10-94-022 mandates the use of telephones and other actions to help reduce excessive waiting times. Efforts will be focused on reducing the number of "walk-ins," i.e., patients who walk into clinics without a scheduled appointment, and "no-shows," i.e., patients who have scheduled appointments and fail to present themselves at the clinic. Also, Information Letter 10-93-031 encourages all VA medical facilities to adopt primary care strategies.

Question 9: Provide VA's goal for outpatient clinic medical record availability. How many VA facilities currently meet and fail to meet this goal. What happens when a facility fails to meet this goal?

How often is medical record availability performance determined at each VA medical facility?

Answer: VA's goal for outpatient clinic medical record availability is 100 percent; however, many factors contribute towards making this goal difficult to attain; factors such as patients with multiple clinic visits on the same day, records transferred from one VA medical center to another, dual division VA medical centers, etc.

There is no nationwide monitor on medical record availability; however, M-1, Part I, Chapter 5, Section 5.08(c) (attached) does suggest that record retrieval for ambulatory/outpatient care visits is a quality assessment tool and should be reviewed by the Chief, Medical Administration Service, on a systematic basis. Corrective action is directed at the facility level when the established goal for record retrieval is not met.

Question 10: Describe the most important findings to date of VA supported research on efficiency and quality of ambulatory care.

Give several examples of systemwide application of the results of VA supported research on efficiency and quality of ambulatory care.

Give several additional examples of how VA's Health Services Research and Development (HSR&D) Service has made a difference in the delivery of ambulatory care to veterans and in the structure of VA medical care.

Answer: Dr. Richard Deyo and his colleagues, at Seattle VAMC, have performed a number of studies related to diagnosis and treatment of back pain. Important findings are that expensive back x-rays are unnecessary in the majority of acute back pain cases; prolonged bedrest is generally unnecessary; return to regular activities within three days produces better outcomes than a week of bedrest; for pain relief and improved function, extensive back surgery does not offer any better relief than does conservative outpatient treatment; and expensive transcutaneous electrical nerve stimulators (TENS) units treatments are no more effective than placebo. In response to Dr. Deyo's studies, many VAMCs now manage patients with back pain much more conservatively than in the past by performing fewer x-rays and surgeries and encouraging patients to return to activity sooner.

Dr. Lewis Kazis and researchers at the Center for Health Maintenance of Aging Veterans, Bedford VAMC, have been conducting studies on quality of life of veterans. Building on the prior experience of investigators using patient-based assessments in large scale observational studies among general populations, the investigators are testing the feasibility of developing and

implementing a study of health outcomes in veterans receiving ambulatory care. This pilot study, known as the Veterans Health Study (VHS), is a longitudinal observational study of veterans in outpatient care selected for one of five common tracer illnesses (hypertension, diabetes, chronic obstructive lung disease, musculoskeletal problems and alcoholism). As a prelude to the main study, a screening of veterans in four VA ambulatory care clinics was conducted. Tracer condition status was determined by a short form screening questionnaire. Results were compared to non-VA ambulatory patient populations from the Medical Outcomes Study, designed to assess health related quality of life impacts in non-VA ambulatory settings. Preliminary findings suggested that veterans' health related quality of life is substantially worse than non-VA populations and may require targeted resources for delivering ambulatory care. The use of patient-centered form questionnaires is practical and can provide the policymaker with useful information for targeting future resources as part of an Outcomes Management System. Patient self-report questionnaires developed through this study have been adapted for clinical use by the VA Neurology Service for assessment of multiple sclerosis patients treated with beta interferon at 35 medical centers.

At Martinez VAMC, Dr. Robert Wertz developed and tested services to appraise, diagnose, and treat veterans who suffer neurogenic communication disorders but reside in areas lacking such services. Patients with a variety of neurogenic communication disorders were appraised and diagnosed using traditional face-to-face methods and computer-controlled video laser disc over the telephone. Findings indicated that appraisal, diagnosis, and treatment using computer-controlled video laser disc over the telephone is an alternative to traditional face-to-face management for patients living where traditional services do not exist. Such patients are now able to receive needed services that would otherwise be difficult or impossible to obtain. The availability of alternative services eliminates frequent and protracted travel to receive treatment and/or the cost and inefficiency of hospitalization to receive services that do not require hospitalization.

While at the Seattle VAMC, Drs. William Carter and Thomas Inui conducted a multi-center study at four VAMCs of a low cost intervention strategy to improve vaccination rates among high risk veterans. The investigation revealed that the intervention increased vaccination rates by over 40 percent as compared with controls. Cost-effectiveness analyses demonstrated that this strategy is highly cost-effective--it saves money in excess of the cost of vaccination by reducing hospitalizations for influenza. This intervention continues to be used at the Seattle VAMC where the annual vaccination rate remains at 80 percent. It also is used by a large HMO, Group Health Cooperative of Puget Sound and by several other VA medical centers.

At VAMC Seattle, Dr. Stephan Fihn developed a computerized system to advise clinicians of the optimal interval at which patients on chronic anticoagulation therapy need to return for clinic visits. In a multi-site randomized trial, patients assigned to the scheduling system made fewer clinic visits and had stable or improved quality of anticoagulation control. This system is in regular use at many VA and non-VA medical centers.

At VAMC Palo Alto, Dr. Denise Johnson developed, implemented, and evaluated a relational database to store and manage clinical data on patients who had undergone treatment for colorectal cancer. The database was designed to identify patients at high risk of having asymptomatic recurrent cancers. In the evaluation phase, 15 percent of patients were identified as having a high probability of cancer recurrence, and therefore were contacted for additional testing, history and physical examinations.

At VAMC Palo Alto, Dr. Steve Lovett conducted a project on the efficacy of outpatient rehabilitation for older veterans with severe visual impairment. As a result of study findings, new methods were implemented in 1991 to establish veterans' rehabilitation goals, which reduced the number of rehabilitation training sessions required with improved patient outcomes. In addition, post-discharge follow-up phone calls were implemented as a standard procedure, because the project showed that phone contact is effective in encouraging continued use of low vision aids and techniques. Services to dementia patients with possible vision loss also were adapted to these patients' particular needs.

Following a GAO report on lack of systematic screening for alcoholism, the HSR&D Service compiled a report on alcohol screening instruments as part of patient intake procedures. This document was distributed to all 171 VA medical centers as a reference for development of improved screening programs.

Question 11: In responding to GAO's draft report, Secretary Brown pointed to VA implementing, its strategic planning goal of 'managed care'.

Provide a copy of VA's strategic planning goal of 'managed care' and VA's schedule for implementing its strategic planning goal of 'managed care'.

Answer: VA's goal is to implement managed care to provide comprehensive, cost effective, coordinated and quality health care to eligible veterans throughout the continuum of health care services available in VHA and implement an interdisciplinary Primary Care Model as a component of a managed-care system.

The following strategies will be implemented to support VA's managed-care goal:

(1) Implement primary care in VHA as a cornerstone of managed care by FY 1996.

(2) Develop and implement financial systems to fully support managed care which include resource allocation, accounting and billing systems by FY 1995.

(3) Develop and implement quality assurance outcome measurements, clinical indicators and reformed patient satisfaction reporting by FY 1995.

(4) Develop and implement educational interventions for present VHA practitioners, new health professions trainees and all health care workers to provide the knowledge and tools to adapt to a patient centered, managed-care environment. Educational interventions will include physician retraining, training nurses to function as nurse practitioners by FY 1995, health care workforce training by FY 1995, training of new health care providers and administrative and management trainees by FY 1995.

(5) Develop infrastructure (equipment and facilities) with emphasis on primary care and that will ensure connectivity to other health care organizations.

(6) Develop integrated information systems that will identify, track, cost and support primary care activities and patients throughout the VHA health care delivery system.

(7) Develop and implement Health Services Research and Development (HSR&D) research and evaluation efforts consistent with managed-care development.

(8) Integrate selected external knowledge-based information sources with internal information systems.

Question 12: The daily patient census in VA medical centers has declined from nearly 57,000 in 1986 to fewer than 43,000 in 1992, a decline of 13,000 patients, according to Department figures. How much of this unused and underutilized space has and can be used to provide outpatient care?

Answer: Based on the experience of the completed Facility Development Plans, we can say that most of the space vacated by bed loss is absorbed by the beds remaining on the wards, since the great majority are space deficient. Modern standards in patient privacy, accessibility, ventilation/air conditioning and life safety all require much more space than was envisioned when these wards were built. The remaining percentage of space is devoted to outpatient functions.

Question 13: The Association of Professors of Medicine (APM) has endorsed residency curriculum reform and shown strong interest in changing the current three-year residency so that 50% of educational time is spent in ambulatory care locations.

Please comment on this proposal.

Answer: VA endorses residency curriculum reform and the dedication of 50 percent of resident training time to be spent in ambulatory care locations. These changes must be established by the Residency Review Committee of the Accreditation Committee on Coordinate Medical Education (ACCME) to become accreditation standards. VA already provides ambulatory care experiences of varying lengths of time for all internal medicine residents. Additionally, VHA has an ambulatory care initiative through which 97 additional positions for ambulatory care training will be funded in Academic Year 94-95. In short, VA is committed to the emphasis on ambulatory care training for residents.

Question 14: According to VHA:

"....aggressive efforts must be made to decrease average waiting times for veterans with scheduled appointments. We would point out that this 30 minute waiting time is not interpreted to be a 'Requirement' but rather a goal to be achieved."

What requirements does VA have for timely delivery of care?

Answer: Outpatient care waiting time policy has been developed and made a part of M-1, Part 1, Chapter 16 (copy attached), requiring monitoring of outpatient waiting times on a quarterly basis. This policy will require VA health care facilities to analyze data collected from monitoring activities to identify clinics experiencing excessive waiting times, determine clinic practices which are causing delays, determine and take appropriate action to correct the problem, review and update clinic profiles to assure activity levels relative to available resources and to assure against scheduling patient appointments in excess of levels recommended by clinic profiles.

Question 15: What has VA done to determine why veterans fail to keep scheduled outpatient appointments and how has VA used this information to reduce the number of missed appointments?

Answer: VA has not conducted nationwide surveys to determine why patients fail to keep appointments. Some facilities have, on their own initiative contacted patients to determine why the appointment was missed.

Question 16: Describe any new or additional authority VA needs to provide ambulatory care which is fully competitive with the best ambulatory care available in the community.

Answer: The Health Security Act proposed by the President provides additional authority to allow VA to compete with other providers. The Health Security Act further allows VA to provide the full continuum of care identified in the benefits package.

VA is currently restricted in its ability to contract with public and private sector medical facilities for medical services which it can offer to eligible veterans in reasonable proximity to the veteran's home.

Question 17: Do VA medical facilities need more or less autonomy to provide more timely services to veterans? Please explain your response.

Answer: VA facilities would benefit from having greater autonomy to address waiting times at individual medical centers. Facilities need flexibility to develop and implement local operating policies and procedures and to explore innovative approaches to improve timeliness of service delivery. Obstacles to timely service usually involve issues of scheduling, uneven workloads for staff, overcrowding during peak hours, and functional deficiencies. These concerns will vary in terms of type of problem and magnitude among facilities. Each medical center needs to assess its unique circumstances within established systemwide standards for provision of timely care and take appropriate actions to adjust service delivery options, patient flows, and staffing patterns to reduce waiting times. This can best be accomplished by allowing field management the flexibility to address those concerns which are identified locally.

Question 18: Why does VA not maintain systemwide data on patient waiting times? When will VA maintain systemwide data on patient waiting times?

Answer: Patient waiting times are unique to each VA facility in that factors causing delays will vary greatly from facility to facility; therefore, data furnished through a systemwide report could potentially be skewed. VA will mandate that each facility conduct waiting time reviews on a quarterly basis and take whatever action is warranted by the results of the reviews.

Question 19: How and when will VA attempt to identify the best clinic practices? When are results expected?

Answer: The national training program: "Primary Care: A Foundation of Managed Care in Health Care Reform," presents several models of primary care and approaches to clinical practice that have been found to be very effective. This information is being shared with each facility representative as they attend these national training programs.

Question 20: How many VA medical centers are currently in compliance with the hospital-based ambulatory care guidelines adopted by VA in 1991?

How have these guidelines improved the delivery of outpatient care to veterans systemwide?

Answer: The guidelines referred to are general guidelines for Hospital-Based Ambulatory Care Programs. They were intended to be guidelines only, and therefore are not mandatory. There needs to be local flexibility in managing ambulatory care based on local requirements and conditions.

Question 21: Why do medical centers continue to use block scheduling in spite of VA policy prohibiting use of block scheduling?

While all four medical centers reviewed by the IG -- Dallas, Indianapolis, Muskogee and San Antonio -- reportedly improperly used block scheduling, Chiefs of Medical Administration at only four medical centers -- Iron Mountain, Erie, Cincinnati and Chicago Lakeside -- admitted to block scheduling use in response to a VA inquiry, even though every MAS Chief in VHA responded to the inquiry according to VA.

Please explain this.

Answer: There seems to be confusion as to the definition of "block scheduling." VA defines "block scheduling" as scheduling all patients to report to a clinic at one specified time. We do not include scheduling a set number at one time as "block scheduling," meaning that if a clinic has two physicians evaluating patients at the same time, it is appropriate to schedule two patients at the same time. In our survey we asked if anyone was scheduling all patients at the same time. The responses received are addressed below.

A response was received from each Chief, Medical Administration Service. Four Chiefs admitted to block scheduling in order to facilitate the work of fee basis physicians and consultants. These persons represented the Chiefs at Iron Mountain, Cincinnati, Erie, and Chicago Lakeside. It was explained that by block scheduling, scarce specialty consultants could see patients who are scheduled for examination on a fee-basis, and then leave, rather than staggering the patients all day, which is costly to this agency in the event of patient "no shows."

Only one Chief of Medical Administration Service (VAMC Northampton) admitted to block scheduling, but when presented with the policy and the ramifications of not following the policy, he obtained management approval to implement scheduling according to the provisions of the policy.

The query elicited a response from many Chiefs which had not been addressed in Agency policy - that of block scheduling for patients who are to receive ancillary services such as laboratory, and radiological tests. Generally, all Chiefs block scheduled patients when the need for ancillary services, e.g., x-ray, lab, etc., existed. For example, laboratory appointments may be scheduled in small groups or blocks at 4 patients every 10 minutes. This practice allows the laboratory technician to process samples of specimens before the next scheduled block of patients arrive. This type of scheduling is acceptable practice.

Several respondents addressed block scheduling for certain health education, rehabilitation medicine clinics such as occupational therapy, and chemotherapy clinics. This practice allows the health care practitioner to address a problem or provide a service common to all selected beneficiaries.

Question 22: Why were clinic profiles not current or not used properly in nearly two-thirds (40 of 67) of the clinics reviewed by the Inspector General?

Answer: Facilities are encouraged to review clinic profiles periodically; however, many factors may contribute toward failure to accomplish the review. If a facility is highly affiliated, the constant rotation of physicians may cause a lapse in updating clinic profiles.

Another factor which may impact on the update of clinic profiles is the decentralized hospital computer package which automatically generates a clinic profile based on data entered at the time the clinic was established. Changes may occur in the actual operation of the clinic; however, the changes are not entered into the computer.

Question 23: How many medical centers have an Associate Chief of Staff for Ambulatory Care?

How many VA medical centers assign each patient to a primary care provider? How many do not?

Answer: There are currently 152 ACOSs for Ambulatory Care.

Each medical center has been directed to implement primary care which includes the assignment of patients to a primary care provider. A video conference, conducted on January 7, 1994, with all medical centers discussed implementation issues and highlighted successful programs. We expect substantial progress in implementing primary care during this fiscal year.

HONORABLE LANE EVANS

Question 24: What improvements in ambulatory care delivery can VA make without additional resources?

Answer: A directive (VHA Directive 10-94-022) to implement TLCP (Telephone Liaison Care Program) was issued on March 18, 1994 (copy attached). This directive mandates the use of the telephone and other actions that will help reduce excessive waiting times.

Efforts will be focused on reducing the number of "walk-ins," i.e., patients who walk into clinics without a scheduled appointment and "no-shows," i.e., patients who have scheduled appointments and fail to present themselves at the clinic.

Information Letter 10-93-031, attached, instructs facilities to review current patient enrollment in specialty clinics, i.e., Cardiology, Pulmonary, Neurology, etc., to determine those patients whose condition can be treated more appropriately in a primary care setting and encourages movement toward primary care.

VA agrees that merely studying patient waiting times will not improve services, but it will tell us where severe problems exist. Therefore, automated computer tracking has been developed which will enable facilities to monitor their waiting times in the outpatient clinics.

Enactment of the President's proposed Health Security Act will help make VA a more competitive health care provider for veterans and dependents. Specific implementation plans are under development within VA but have not been approved by the Secretary at this time.

Question 25: GAO reported 75% of the veterans visiting emergency/screening clinics had non-emergent conditions. What specific actions will VA take this fiscal year to reduce such unnecessary visits?

Answer: The Telephone Liaison Care program (TFCP) directive will result in the number of "walk-ins" and "no-shows" being reduced by allowing veterans to access the medical care system by telephone without having to physically come into the clinic.

Question 26: Why do over 40% of VA's emergency/screening clinics not allow veterans to schedule visits?

Answer: If patients were allowed to schedule appointments without eligibility assessments, it is likely ineligible patients would inappropriately occupy appointment timeframes. Without a clinical assessment, it is likely patients would be inappropriately scheduled in a general medical or primary care clinic when they should have been scheduled in a specialty clinic such as Hypertension Clinic, Diabetes Clinic, Pulmonary Clinic, Cardiology Clinic, etc. With patients inappropriately scheduled in such clinics, timely appointments would not be available to patients whose care would be appropriate to these clinics.

Page 14

HONORABLE LANE EVANS

Question 27: VA has received numerous veteran service organization reports of long waits for outpatient care at VA facilities. Describe VA's use, if any, of these site visit reports to improve ambulatory care delivery systemwide.

Answer: All Veterans Service Organization (VSO) reports are closely reviewed for information which may assist VA in better operating its facilities. As a result of recent reviews, MAS sent out a message on a nationwide conference call reminding stations to monitor their clinic availability. This is an automatic computer option that the station may generate at their discretion.

QUESTIONS SUBMITTED BY
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SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

VA AMBULATORY CARE TIMELINESS AND RELATED ISSUES

OCTOBER 27, 1993

Question 1: In commenting on GAO's draft report, VA HEALTH CARE: Restructuring VA's Ambulatory Care System would Improve Services to Veterans, the Secretary stated that "as VA implements its strategic planning goal of managed care, we will create an enhanced service to our veterans as well as implement your recommendations". Specifically when does VA plan to implement the four recommendations by GAO for restructuring the ambulatory care program to improve timeliness of services? What steps are involved in restructuring the ambulatory care program?

Answer: The four recommendations made by the GAO for restructuring Ambulatory Care to improve timeliness of services and their implementation dates are as follows:

1. Establish telephone assistance networks: This directive was issued on March 18, 1994.

2. Allow veterans to schedule appointments to receive care at general medicine clinics: As part of the telephone assistance program veterans will be encouraged to call in to make appointments in general medicine or primary care clinics. On October 28, 1993, Information Letter 10-93-031: "Primary Care as a VHA Priority" (copy attached) was distributed to the field. This letter asked that the field move ahead with primary care initiatives.

3. Require all facilities to develop treatment monitoring systems that ensure all veterans referred to specialty clinics are transferred to general medicine or primary care clinics as soon as their conditions are stabilized: Information Letter 10-93-031 addresses the need to review specialty clinics to identify patients who can be more appropriately tracked in primary care clinics.

4. Establish Department-wide performance goals for timely service delivery and gather systemwide data that will allow facilities' performance to be measured against established goals: During January 1994, VHA conducted an extensive review of the requirements needed to meet the challenge of national health care reform. Health care reform work groups made recommendations on how primary care could be structured and what changes would be needed to implement primary care to the maximum extent in VA. In the context of health care reform VHA will match performance standards that are developed and directed by the Regional Health Alliances. Once these expectations are codified, performance goals based on them will be drawn up and sent to the field for comment. Data capture methodologies will be developed to measure these goals. It is anticipated that we will have this system in place in early 1995.

HONORABLE TOM RIDGE

Question 2: GAO reported that veterans frequently waited 8 to 9 weeks to obtain appointments in the specialty clinics surveyed? Wouldn't you agree that this is an inordinate length of time to wait for treatment of a condition that could possibly be life-threatening? How does this time period compare with that of private sector specialty clinics? How much of this delay can be attributed to underfunding? How much of this delay can be attributed to inadequate space and facilities?

Answer: Waiting 8 to 9 weeks to obtain appointments in specialty clinics is not an acceptable timeframe. As pointed out in the GAO report, the telephone access program will decrease this time by allowing veterans to access health care providers in a timely manner. Information Letter 10-93-031: "Primary Care as a VHA Priority" will also aid medical centers in shifting patients from these busy specialty clinics to general medical or primary care clinics. This will then allow other patients to be seen in the specialty clinic with a much shorter waiting time. Patients who have life-threatening conditions are seen immediately.

There are, to our knowledge, no standards for waiting times for specialty clinics in the private sector. Once VA develops its waiting time standards, these may, in fact, become the national standards.

The Telephone Liaison Care Program directive will provide some help in decreasing waiting times, improving access to care providers and reducing unnecessary clinic visits. If patients are transferred from specialty clinics to general medicine and primary care clinics as their medical conditions allow, the waiting times to see a specialist will be reduced.

We do not have a breakdown of the causes of delay comparing underfunding and inadequate facilities.

Question 3: As you stated, outpatient services are provided at 170 medical centers. How many medical centers currently have established telephone assistance networks? Are there plans to establish others.

Answer: Only a few medical centers have adopted the Telephone Liaison Care Program at this time; however, VA has just issued Directive 10-92-022 (copy attached) to require all facilities to initiate telephone assistance networks. We expect substantial progress toward this goal during this fiscal year.

Question 4: One of the initiatives you state is underway to improve VA's ability to provide outpatient services is the establishment of mobile labs in ambulatory care areas. How have they proven to be efficient?

Answer: At the present time, Pathology and Laboratory Medicine Service is still conducting its two Mobile Lab(R) pilot projects. This study is a hybrid cost-effectiveness analysis measuring both cost and health benefits. Final results are expected in mid-1994.

Question 5: What do you mean by implementation of the so-called strategic planning goal of "managed care?" Do you have any costs estimates for implementation of the so-called strategic planning goal of "managed care"?

Answer: VA's goal is to implement managed care to provide comprehensive, cost effective, coordinated and quality health care to veterans throughout the continuum of health care services available in VHA and implement an interdisciplinary Primary Care Model as a component of a managed care system.

The following strategies will be implemented to support VA's managed care goal:

(1) Implement primary care in VHA as a cornerstone of managed care by FY 1996.

(2) Develop and implement financial systems to fully support managed care which include resource allocation, accounting and billing systems by FY 1995.

(3) Develop and implement quality assurance outcome measurements, clinical indicators and reformed patient satisfaction reporting by FY 1995.

(4) Develop and implement educational interventions for present VHA practitioners, new health professions trainees and all health care workers to provide the knowledge and tools to adopt to a patient centered, managed care environment. Educational interventions will include physician retraining, training nurses to function as nurse practitioners by FY 1995, health care workforce training by FY 1995, training of new health care providers and administrative and management trainees by FY 1995.

(5) Develop infrastructure (equipment and facilities) with emphasis on primary care and will ensure connectivity to other health care organizations.

(6) Develop integrated information systems that will identify, track, cost and support primary care activities and patients throughout the VHA health care delivery system.

(7) Develop and implement Health Services Research and Development (HSR&D) research and evaluation efforts consistent with managed care development.

(8) Integrate selected external knowledge-based information sources with internal information systems.

Question 6: In light of the upcoming national health care reform, VA for the first time, may be put in the position of competing with the private sector for patients. Obviously, inordinate waiting times is a serious disincentive for a veteran to choose VA if given an alternative in the private sector. What plans does VA have to make its facilities more customer-oriented? Specifically, will the Department request legislative authority to make it easier to dismiss career employees who do not put the customer first?

Answer: The vast majority of Veterans Health Administration employees have always put the veteran first as they work to provide quality health care. The VA does not plan to request legislative authority to make it easier to dismiss career employees who do not put the customer first because there are sufficient authorities in place now to deal with such situations. In addition, recent changes to the VA's Title-38 disciplinary authorities do, in fact, make the process of dealing with a problem Title-38 employee much easier. Finally, VA has delegated more authority to VHA field stations to take disciplinary action, up to and including discharge, where necessary.

HONORABLE LANE EVANS
ATTACHMENT TO QUESTION #2
- ALSO -
HONORABLE TOM RIDGE
ATTACHMENT TO QUESTION #1

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

IL 10-93-031

In Reply Refer To: 10A

October 28, 1993

UNDER SECRETARY FOR HEALTH'S LETTER

TO: Regional Directors; Directors, VA Medical Center Activities, Domiciliary, Outpatient Clinics and Regional Offices with Outpatient Clinics

SUBJ: Primary Care as a VHA Priority

1. Health care in the United States is in a time of transition and the Department of Veterans Affairs (VA) must change and improve its health care delivery system to ensure its role in national health reform. VA must be an active participant in the change process while ensuring continuity of quality care to our veterans.

2. The importance of managed care and the need to continue moving in that direction has been recognized. A Veterans Health Administration (VHA) Managed Care Task Force was appointed to develop a managed care strategy, building upon VHA's existing managed care foundation. Further implementation of managed care in VHA will require a shift from the provision of episodic care delivered by individual medical facilities to a coordinated continuum of care emphasizing primary care within referral networks.

3. Primary care is the foundation of managed care. It is the coordinated interdisciplinary provision of health care consisting of:

a. Intake and initial needs assessment;

b. Health promotion and disease prevention;

c. Management of acute and chronic biopsychosocial conditions;

d. Access to other components of health care;

e. Continuity; and

f. Patient and non-professional care giver education and training.

4. We know there is a need for primary care and we must move in that direction. Primary care was discussed at the recent regional/network budget meetings and many of you are already practicing primary care. As health reform may differ by State and individual facility situations can be unique, it is difficult to prescribe any "best" primary care model. You are encouraged to be innovative in your approach to the implementation of primary care.

IL 10-93-031
October 28, 1993

5. I am requesting you to move forward with primary care initiatives. Each VA medical center needs to begin the following activities:

a. Develop an implementation plan and begin implementing primary care.

b. Review specialty clinics to identify patients who can be more appropriately treated in primary care clinics. This movement of patients into primary care clinics will allow more timely consultation and treatment of patients referred for specialty care. It will be necessary to consider staffing for primary care.

c. Evaluate 5-year facility plans to ensure that the high priorities of managed and primary care are reflected in proposed construction projects.

d. Consult affiliates regarding primary care training and educational requirements.

e. Develop and enhance information systems which support managed care and primary care and provide for timely flow of patient information within and among care sites.

f. Continuously review ambulatory care programs for opportunities to reduce waiting times and improve efficiencies and customer satisfaction.

6. VA Central Office program offices are being charged to make primary care a priority and assist you in any way possible. We are currently modifying the Resource Planning and Management (RPM) process to incorporate incentives for providing primary care. The RPM-Field Oversight Committee is providing input into this process and an RPM Primary Care Technical Advisory Group (TAG) is being established to provide additional guidance.

7. As we enter the national health care reform arena, issues of quality, cost and responsiveness of care providers will be paramount. We can build on our strengths in these areas and use innovative approaches to improve continuously. VHA is committed to maintaining our leadership role in patient care, education and research and will do everything possible to ensure that the VA medical program will be the plan of choice for America's veterans.

8. Your support in this effort is essential and greatly appreciated.

John T. Farrar, M.D.
Acting Under Secretary for Health

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amount of additional duties they perform, and the depth of review needed to assure completeness and accuracy of coding. The supervisor of the Medical Record activity will determine the number of records to be reviewed and coded daily by each clerk. The number of records reviewed and coded monthly should equate to the average number of discharges monthly.

5.08 QUALITY ASSESSMENT OF MEDICAL RECORD SERVICES

a. Periodic, systematic evaluation of the quality of medical record services is essential to the effective management of a medical record program.

b. The Chief, Medical Information Section, in conjunction with the Chief, Medical Administration Service, will develop a plan for assessing the quality of service performed by Medical Information Section personnel. This plan may incorporate topics being evaluated in the facility's systematic internal review program, but duplication of studies or reports will be avoided.

c. Topics for evaluation may include: record retrieval for ambulatory/outpatient care visits; timely filing of reports on ambulatory/outpatient care records; quality control of transcription services; training of medical record personnel; assistance provided to professional personnel on research projects and quality assurance activities; timeliness of medical record processing; timeliness of release of information activities; adequacy of billing procedures; reviews specified elsewhere in this chapter and other activities which are germane to the delivery of quality medical record services.

d. Validation of PTF (Patient Treatment File) data will be performed at locally established intervals. The validation process will include a qualitative review and evaluation of the clinical as well as administrative information reported into the PTF system.

(1) The results of qualitative reviews of diagnostic and operative/procedural coding will be documented by the Chief, Medical Information Section or designee, and will identify inaccurate, inadequate, and inconsistent coding practices; provide an analysis which identifies the cause(s) of the problem(s); provide recommendations for corrective action; and provide a timeframe for implementation of the recommendations and reassessment of the previously identified inaccurate, inconsistent, and inadequate data.

(2) Qualitative reviews of diagnostic and operative/procedural coding will be performed on a concurrent basis and/or on a retrospective basis. For the purpose of this subparagraph, a concurrent review is one performed on the day of or the workday following the initial code assignments. Retrospective ICD-9-CM coding reviews should address a homogeneous population, e.g., all patients reported with a diagnosis of myocardial infarction; all patients reported with a diagnosis of AIDS, pneumonia, diabetes, etc.

(3) Where feasible, the review will be performed by an individual who did not participate in the assignment of the original codes. The review, however, will ensure conformance with medical record documentation requirements, and ICD-9-CM coding guidelines and conventions.

(4) The quality review of administrative data will be performed in accordance with PTF instructions and will identify the same data as is recommended in subparagraph (1) above.

c. Any veteran properly enrolled in an approved OPT Program will be furnished required examinations, treatment, rehabilitative services, medications, and supplies to which they are legally eligible, and which have been ordered by the responsible physician.

16.21 TIME STUDIES

Outpatient clinic waiting time studies will be performed on a quarterly basis by DHCP or, if DHCP is not available, manually. The results of these reviews *MUST* be constructed in such a manner as to allow for the collection and analyze of such problems as excess waiting times and potential causes for delays. The Chief, MAS, will analyze the time studies and the findings will be furnished to the medical center Director. The medical center Director is responsible for ensuring appropriate action is taken to correct any problems identified.

16.22 OUTPATIENT TREATMENT - SERVICE-CONNECTED (OPT-SC)

OPT-SC conditions will be provided to the fullest extent for the usual curative and maintenance purposes. In addition, care will be afforded to preclude or limit regression and/or the need for hospitalization. All necessary resources of the VA medical program will be used in this objective.

16.23 OUTPATIENT TREATMENT - NONSERVICE-CONNECTED (OPT-NSC)

a. OPT-NSC will be planned to facilitate early release and to ensure optimum results from the episode of hospitalization, nursing home care or domiciliary care. When medical care has progressed to the point where it is reasonable to anticipate that treatment for the condition for which care was required may be concluded satisfactorily on an outpatient basis, the patient will be released from inpatient care (including nursing home and domiciliary care) and an appointment arranged for OPT-NSC treatment. Not all patients released from inpatient care will require outpatient care.

b. A patient in OPT-NSC status will be furnished treatment at the VA facility from which the patient was released/discharged from an inpatient status to an OPT-NSC status.

(1) A patient will never be referred for OPT at another facility without advance agreement between the facilities. If an agreement cannot be reached, OPT will be provided at the place of inpatient care or domiciliary care and the appropriate Regional Director will be advised and furnished copies of appropriate documents and correspondence.

(2) Veterans receiving hospital care at VA expense in other Federal medical centers may return to those facilities for OPT, or to another VA facility, only with advance agreement.

(3) A patient referred for followup care at another facility will not be released from OPT status by the receiving facility without reexamination, except when release is indicated because the veteran fails to keep scheduled appointments.

(4) Veterans receiving OPT care at a VA facility who need supplemental diagnostic services that cannot be provided economically at that VA, or other VA health care facility, will be provided those services on a fee or contract basis using that facility's regular medical care operating funds.

HONORABLE TOM RIDGE

ATTACHMENT TO QUESTION #3

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 10-94-022

March 18, 1994

TELEPHONE LIAISON CARE PROGRAM (TLCP)

1. PURPOSE: The purpose of this Veterans Health Administration (VHA) Directive is to provide guidance for establishment of local Telephone Liaison Care Programs.

2. BACKGROUND: Department of Veterans Affairs (VA) is committed to developing innovative programs to improve our customer focus. Telephone Liaison Care programs have the potential for improving access to care providers, reducing unnecessary clinic visits and decreasing waiting times.

3. POLICY: Every VA medical facility will develop and institute a Telephone Liaison Care Program, the goal of which will be to allow patients and families to contact the facility by telephone to discuss any concerns relevant to access to care, (eligibility and scheduling), medical concerns, (treatment and follow-up), and questions about medications.

4. ACTION

a. Telephone Liaison Care is a part of any facility's Ambulatory Care Program. It should be available to all patients and integrated into existing health care delivery systems including firms, primary care programs and urgent care clinics.

b. Telephone Liaison Care should be provided by qualified individuals who have been provided clear guidance and training. A facility may provide telephone access using staff members from a variety of services (e.g., Medical Administration, Nursing, Pharmacy) to address issues relevant to their individual services and responsibilities. In all cases there must be coordination among services to ensure that interdisciplinary problems are fully addressed.

c. Individuals providing Telephone Liaison Care must have ready access to patient medical records, including current pharmacy profiles. In most cases, this will require access to the hospital computer system.

d. Clinical advice may be provided only by registered nurses, physicians, physician assistants, or other individuals who, in the opinion of the Chief of Staff, or designee, are qualified by virtue of training and experience.

e. Stop codes have been established for each respective cost distribution account and are defined in Attachment A. Telephone visits are defined as a telephone call between clinical/professional staff and a patient:

(1) To coordinate medical clinical/advice to an established patient on a new problem,

(2) To initiate therapy that can be coordinated by telephone,

(3) To discuss test results in detail,

(4) To provide medication refills or adjust medications, or

THIS VHA DIRECTIVE EXPIRES MARCH 18, 1997

(5) To initiate a new plan of care.

f. Telephone calls concerning eligibility or other administrative issues do not constitute a telephone visit as no medical intervention is involved.

g. Telephone visits will be counted as facility workload for budgeting purposes.

h. Those specialties, i.e., Social Work, Nursing, Dietetics, Psychology, etc., which are reported in Cost Distribution Report (CDR) account 2611.00 that want to report workload activities may establish specific clinics with their treating specialty stop codes and the telephone/ancillary stop code number 147.

i. The Medical Care Cost Recovery Program Office has determined that health care services provided via telephone contacts are nonbillable as outpatient visits to insurance carriers. These visits will not result in a billable event, however, should the telephone contact result in the provision of a prescription or a refill, the $2.00 prescription copayment will be required if applicable. When the telephone contact results in the provision of a new prescription or a refill, a claim will be submitted to the insurance carrier for a prescription refill.

j. Activities accomplished through TLCP must be documented in the patient's medical record (or electronic medical record). The provisions of the Privacy Act, Title 5, United States Code, Section 552a, and 38 U.S.C. Section 7332, which concern the privacy and confidentiality of patient information, apply to any conversations relative to a patient's condition and/or treatment with individuals other than the patient.

k. Every facility must have a mechanism for making patients aware of its Telephone Liaison Care Program, including the phone number, a description of the types of problems which are appropriate for calls, hours of operation and instructions for obtaining services during non-administrative hours.

l. Telephone Liaison Care should be monitored and evaluated on an ongoing basis as part of the facility's Quality Management activities.

5. REFERENCES

a. General Accounting Office Report (GAO-HRD 94-4), "VA Health Care. Restructuring VA's Ambulatory Care System Would Improve Services to Veterans," dated October 15, 1993.

b. Office of Inspector General Report (3R6-A99-154), "Audit of Outpatient Waiting Times in Department of Veterans Affairs Medical Centers," dated September 30, 1993.

c. M-1, Part I, Chapter 16, Paragraph 16.17, "Scheduling."

d. M-1, Part I, Chapter 9.

6. FOLLOW-UP RESPONSIBILITY: Deputy ADCMD for Ambulatory Care (112).

7. RESCISSIONS: This VHA Directive will expire on March 18, 1997.

John T. Farrar, M.D.
Acting Under Secretary for Health

Attachment

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ATTACHMENT A

NEW CLINIC STOP CODES
**added in middle of Fiscal Year 1994

STOP CODE	CDR ACCOUNT	DEFINITION
103	2111.00	Telephone Triage: Records patient consultation or medical care management/advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and the clinical/professional staff assigned to the admission/emergency services area. Includes administrative and clinical services.
324	2110.00	Telephone/Medicine: Records patient consultation or medical care management/advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to the medicine service. Includes the administrative and clinical services.
424	2210.00	Telephone/Surgery: Records patient consultation or medical care management/advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and the clinical/professional staff assigned to the surgical service. Includes the administrative and clinical services.
526	2310.00	Telephone/Special Psychiatry: Records patient consultation or medical care management/ advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to the special psychiatry service. Includes the administrative and clinical services. **Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, diagnosis, prognosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with human immunodeficiency virus, or sickle cell anemia, are strictly confidential and may not be released/discussed unless there is a written consent from the individual.

527	2311.00	Telephone/General Psychiatry: Records patient consultation or medical care management/ advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to the general psychiatry service. Includes the administrative and clinical services. **Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, diagnosis, prognosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with human immunodeficiency virus, or sickle cell anemia, are strictly confidential and may not be released/discussed unless there is a written consent from the individual.
542	2313.00	Telephone/PTSD: Records patient consultation or medical care management/advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to the PTSD Clinical Team. Includes the administrative and clinical services. **Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, diagnosis, prognosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with human immunodeficiency virus, or sickle cell anemia, are strictly confidential and may not be released/discussed unless there is a written consent from the individual.
543	2316.00	Telephone/Alcohol Dependence: Records patient consultation or medical care management/ advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to the alcohol dependence treatment team. Includes the administrative and clinical services. **Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, diagnosis, prognosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with human immunodeficiency virus, or sickle cell anemia, are strictly confidential and may not be released/discussed unless there is a written consent from the individual.

544	2316.00	Telephone/Drug Dependence: Records patient consultation or medical care management/ advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to the drug dependence treatment team. Includes the administrative and clinical services. **Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, diagnosis, prognosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with human immunodeficiency virus, or sickle cell anemia, are strictly confidential and may not be released/discussed unless there is a written consent from the individual.
545	2316.00	Telephone/Substance Abuse: Records patient consultation or medical care management/ advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to the substance abuse treatment team. Includes the administrative and clinical services. **Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, diagnosis, prognosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with human immunodeficiency virus, or sickle cell anemia, are strictly confidential and may not be released/discussed unless there is a written consent from the individual.
147	2610.00	Telephone/Ancillary Records patient consultation or medical care management/advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to: Nursing, public health nursing, nutrition/dietetics, social work service, or clinical pharmacy. Includes administrative and clinical services.

216	2611.00	Telephone/Rehab. and Support: Records patient consultation or medical care management/ advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to rehabilitation and support services. Includes administrative and clinical services.
148	2612	Telephone/Diagnostic: Records patient consultation or medical care management/ advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff associated with: pulmonary function, x-ray, EEG, EKG, laboratory, nuclear medicine, ultrasound, evoked potential, topographical brain mapping. Includes administrative and professional services.
425	2614.00	Telephone: Prosthetics/Orthotics: Records patient consultation or medical care management/ advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to prosthetics/orthotics. Includes administrative and professional services.
181	2710.00	Telephone/Dental: Records patient consultation or medical care management/advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to Dental service. Includes administrative and professional services.
611	2410.00	Telephone/Dialysis: Records patient consultation or medical care management/advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to Dialysis treatment team. Includes administrative and professional services.

525	2311.00	WOMEN'S STRESS DISORDER TREATMENT TEAMS: Records contacts with veterans seen by Women's Stress Disorder Treatment teams at officially Central Office (CO) designated VA Medical Centers.

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